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ABSTRACT

This report describes what has been learned in the first year of a study to examine collaborative community initiatives designed to improve low-income families' access to good-quality infant-toddler child care; the report examines the Early Head Start/child care partnerships in detail and identifies emerging themes to consider in more depth as the study continues. The research questions guiding the study addressed five broad themes: quality, affordability, state policy, barriers faced by families, and challenges to collaboration. A literature view, interviews with government officials, child care researchers, and other experts and focus groups conducted with child care providers, Early Head Start staff, and others serving families with infants and toddlers were used to identify promising collaborative community partnerships working to address comprehensively the barriers faced by families. Key players in these partnerships were interviewed. Findings indicated that staff of Early Head Start/child care partnerships could point to progress in a number of specific areas: improving quality, expanding supply and improving access, getting more resources for child care providers, increased community collaboration, and building community awareness of early childhood issues. Enduring challenges were identified and may be similar to those faced by like initiatives: improving quality while complying with performance standards, achieving and maintaining continuity of care, matching child care arrangements to families' needs, and staffing issues. Future study will involve the development of case studies of collaborative infant-toddler child care initiatives in three diverse communities. The report's appendix includes the telephone interview and focus group discussion guides. (Contains 65 references.) (KB)

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Partnerships for Quality: Improving Infant-Toddler Child Care for Low-Income Families

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EXECUTIVE SUMMARY

The demand for good-quality child care has increased in the wake of welfare reform, as many low-income families have entered the workforce and confronted difficulties arranging, paying for, and sustaining the continuity of child care. Infant-toddler child care is scarce in most communities across the U.S., particularly in low-income communities. It is also expensive. Even with the increased availability of child care subsidies, many low-income families face difficulties paying for care. And, although the quality of child care can be a critical influence on the well-being of infants and toddlers, finding good-quality infant-toddler child care can be especially challenging for low-income families.

To address these families' needs, federal and state governments have increased funding for child care and supported special quality initiatives focused on the unique challenges of infant and toddler care. Nevertheless, child care and child development service systems are often fragmented, as are efforts to improve child care quality. Policymakers and program operators have begun to collaborate and develop partnerships to improve coordination across systems and address the child care needs of working parents. These efforts, however, have not necessarily focused on infant-toddler child care.

In fall 2000, ZERO TO THREE and Mathematica Policy Research, Inc. (MPR) obtained funding from the Child Care Bureau of the U.S. Department of Health and Human Services (DHHS) to conduct an in-depth study of collaborative community initiatives designed to improve low-income families' access to good-quality infant-toddler child care. This interim report describes what we have learned in the study's first year about promising strategies for building community collaborations and partnerships, as well as preliminary operational themes that may be helpful for programs, communities, and state and federal policymakers who seek to develop, implement, and support partnership strategies. Because Early Head Start has been at the forefront of efforts to promote the development of community partnerships—especially those with child care providers—to help meet the unique needs of families with infants and toddlers, the report examines these Early Head Start-child care partnerships in detail. A comprehensive report of the study's findings, including lessons for policymakers and program operators derived from the experiences of

child care partnerships and other collaborative child care initiatives, will be completed in fall 2002.

The Research Questions

The research questions that guide our study address five broad themes: (1) quality, (2) affordability, (3) state policy, (4) barriers faced by families, and (5) challenges to collaboration. The questions included the following:

- What community strategies have been implemented to improve the quality of infant-toddler child care used by low-income families? What are the processes of collaboration, and how long does it take to form partnerships and address issues related to the quality of infant-toddler care?
- What community strategies have been implemented to help low-income families pay for good-quality infant-toddler child care?
- How have communities worked with states to access funding and develop policies that address the needs of low-income families with infants and toddlers for affordable, accessible, good-quality child care?
- What barriers do low-income families face in accessing good-quality child care for their infants and toddlers?
- What challenges do child care providers and other community service agencies serving this population (such as Early Head Start programs) face? In particular, what are the challenges to implementing collaborative initiatives and partnerships to increase families' access to good-quality infant-toddler child care?

Because collaborative community strategies for addressing the child care needs of low-income families with infants and toddlers have not been well documented in other research, this study is exploratory in nature. Using an iterative process to identify data sources and collect data for the study, we began by reviewing recent literature on the barriers faced by low-income families who need infant-toddler child care and the strategies that have been implemented to address these barriers. We then conducted interviews with a range of government officials, child care researchers, and other experts and conducted focus groups with child care providers, Early Head Start staff, and others who serve families with infants and toddlers. Based on this initial round of data collection, we identified promising, collaborative community partnerships that are working to address comprehensively the barriers faced by families. We interviewed key players in these partnerships. This interim report summarizes what we learned about these partnerships during the study's first year and identifies emerging themes that we plan to explore in more depth as the study continues.

IDENTIFYING THE BARRIERS

Low-income families with infants and toddlers face significant child care challenges. The barriers to finding and maintaining good-quality child care for children under age 3, as described in recent literature and identified by child care providers and Early Head Start staff include:

- **The supply of infant-toddler care is insufficient.** Many parents face long waiting lists because few infant-toddler slots are available. Regulated infant-toddler care—which is more likely to be of high quality—is especially scarce in low-income neighborhoods. It is also scarce for families who need part-time care and families who need care during nontraditional work hours, as well as for infants and toddlers with special needs and sick children.

- **Most infant-toddler care is not of good quality.** Research has shown that a large proportion of child care for infants and toddlers is not of good quality. Low-income families, in particular, may have limited choices in child care providers because of cost or location constraints. As a result, they tend to rely on poorer-quality child care arrangements, compared with higher-income families.

- **Infant-toddler care is expensive.** The high cost of this type of care affects low-income families disproportionately. They often pay a higher proportion of their income for child care than higher-income families. Many low-income families without access to subsidies cannot afford to pay for regulated child care.

- **Accessing and maintaining state child care subsidies are difficult.** Funding for state child care subsidies is insufficient to serve all eligible families. As a result, states prioritize families to determine which ones will receive assistance. Some eligible families have trouble getting and keeping state subsidies for reasons that include a lack of information about subsidy availability, transaction costs, administrative barriers, structure and level of co-payments, and availability of providers who accept subsidies.

- **Information about the availability and quality of infant-toddler care is lacking.** States face constraints in providing adequate consumer information to parents, and low-income families who are not linked to the welfare system may find access to information especially difficult. Families lack adequate information about the availability and quality of specific child care arrangements. In addition, language barriers prevent some families from accessing consumer information.

- **Transportation to child care can be difficult to arrange.** Because infant-toddler child care is in especially short supply in neighborhoods where low-

income families live, many need transportation to care. Transportation barriers can be severe for families in rural areas, where public transportation may not be available, and for parents who work late shifts and need transportation after public transit stops running.

Federal, State, and Community Responses

During the past decade, the federal government, states, and communities have initiated efforts to expand child care supply and improve quality. Not all of these initiatives focus on infant-toddler care, or even on low-income families. Nevertheless, as a whole, they provide important context for understanding strategies being used to promote access to good-quality infant-toddler child care for low-income families. The main initiatives identified include:

- **Child Care and Development Fund (CCDF).** The Personal Responsibility Work Opportunities Reconciliation Act (PRWORA) created CCDF, the primary federal child care funding stream. This federal initiative combined four federal child care programs into a single block grant to states, increased federal funding, and gave states more flexibility in spending the funds. CCDF also requires states to set aside four percent of their grant for quality improvement and additional funds for improving the quality of infant-toddler care. Within broad limits, states have flexibility in setting income eligibility requirements, fee schedules for parent co-payments, and provider reimbursement rates.

- **Local Planning Initiatives.** Several states—including California, Iowa, and North Carolina—have developed initiatives to plan and coordinate early childhood services at the local level. These states provide a broad structure and resources to local planning boards, which plan and implement services based on local community needs and resources.

- **Initiatives Designed to Increase Supply.** States and communities have implemented initiatives to increase the supply of regulated child care, such as supporting new family child care providers, developing new child care facilities, and offering tiered provider reimbursement rates (from CCDF funds) to increase the supply of certain types of care (for example, infant-toddler care or care during nonstandard hours).

- **Initiatives Designed to Improve Quality.** Strategies for improving the quality of care include provider training and education, technical assistance initiatives, support networks for nonregulated "kith and kin" providers, support for obtaining accreditation, Early Head Start-child care partnerships, tiered reimbursement rates that pay more to higher-quality providers, and public rating systems that identify higher-quality providers.

- **Public-Private Partnerships.** Communities have implemented strategies to finance child care services through public-private partnerships, including loan and grant programs, corporate tax incentives, and information and referral assistance.

Strategies for Building Early Head Start-Child Care Partnerships

Although we identified a number of strategies that states and communities are using to expand and improve child care supply and quality, not all of them focus specifically on infant-toddler care and care for low-income families. In addition, in some communities, the initiatives did not appear to be well-coordinated. Early Head Start-child care partnerships, however, are good examples of initiatives that target both the need to improve quality and supply for low-income families and the need to focus on access and quality specifically for infant-toddler care.

The experiences of the Early Head Start-child care partnerships can provide useful information for policymakers and program operators who seek to implement similar partnership or community collaborative strategies to help low-income families access good-quality infant-toddler child care. We also found that most of the Early Head Start-child care partnerships we examined were collaborating not only within the partnership, but also with community child care resource and referral agencies (CCR&Rs), community colleges, health-related initiatives (for example, Healthy Child Care America projects), or other community agencies. Other initiatives and partnerships seeking to expand families' access to good-quality infant-toddler care might also benefit from these community resources.

Head Start Program Performance Standards

Early Head Start, which began in 1995, extended Head Start services to low-income pregnant women and families with infants and toddlers up to age 3. A comprehensive, two-generation program, it focuses on enhancing children's development while strengthening families. Today, more than 640 programs across the nation serve more than 55,000 families.

Early Head Start programs must adhere to the revised Head Start Program Performance Standards (HSPPS), which took effect in January 1998 (Administration for Children and Families 1996). These standards lay out requirements for the quality of early childhood development and health services, family and community partnerships, and program design and management and establish a set of expectations for the quality of services provided in child care settings. For example, the standards require that care be developmentally appropriate and designed to promote the formation of secure relationships by providing continuity of care. Child care teachers must have a Child Development Associate (CDA) credential or higher degree within a year of hire. Children must be cared for in groups of no more than eight, with at least one teacher for every four children.

The Head Start Bureau expects Early Head Start programs to take responsibility for helping to arrange child care for all families who need it. Moreover, programs must ensure that their child care arrangements, whether provided in a program-operated child care center or through a community child care provider, adhere to relevant performance standards.

Developing the Partnerships

To meet families' child care needs, many Early Head Start programs have developed partnerships with child care providers in the community that agree to work toward meeting the performance standards. Partnerships, which develop in response to families' child care needs, community characteristics, and available resources, vary from one community to another. We identified three main types of partnerships: (1) comprehensive partnerships, (2) subsidy enhancement partnerships, and (3) technical assistance partnerships.

These partnerships vary in their staffing configurations, partnership agreements, financial arrangements, and intensity of support and technical assistance offered to child care providers (Table 1). In turn, these differences affect implementation—both the challenges partnerships face and the successes they achieve. Next, we describe key characteristics of the Early Head Start-child care partnerships studied.

Staffing. Almost all Early Head Start programs name a provider liaison to serve as the primary contact with child care providers. Typically, liaisons participate in provider recruitment and selection, visit child care partners regularly to offer technical assistance in implementing the HSPPS, and loan or provide equipment, toys, and consumable supplies to child care providers. They also help teachers with professional development, which includes creating individual professional development plans, and coordinating CDA and other training. Other Early Head Start staff, such as family advocates or disabilities specialists, supplement this support. Some programs also bring in staff from other community agencies to support the partnerships.

Provider Recruitment. In most of the partnerships we studied, Early Head Start programs try to recruit both centers and family child care homes. Only a few recruit one or the other exclusively, usually because of the limitations in available child care supply or resources available to invest in partnerships. Most programs recruit partners by extending an open invitation to all licensed child care providers in the community. They send mailings, obtain recommendations from child care resource and referral agencies, advertise in local newspapers, post fliers, and invite providers to orientation sessions. Some programs recruit new family child care providers and help them become licensed. A few do not recruit widely, because they have decided to concentrate their resources on a few selected child care partners.

Partnership Agreements. Formal agreements are central to Early Head Start-child care partnerships, because they document the expectations and obligations of each partner. Often, they represent the culmination of an in-depth decision-making process about whether to go forward with the partnership, as well as a negotiation phase in which the terms of the

TABLE 1

KEY CHARACTERISTICS OF EARLY HEAD START-CHILD CARE PARTNERSHIPS

Partnership Characteristics	Comprehensive Partnerships	Subsidy Enhancement Partnerships	Technical Assistance Partnerships
Partnership Agreements	Formal contract for specific number of slots that meet the HSPPS	Formal contract for specific number of slots that meet the HSPPS	Partnership agreement that specifies steps the provider will take to meet the HSPS. Programs do not contract for specific numbers of slots.
Level of Financial Support	Program pays a per-child rate to cover the full cost of care. Additional costs of meeting the HSPPS are covered, such as extra staff needed to meet ratios, CDA training (cost of courses, compensation for teachers while they attend classes, compensation for substitutes), bonuses for qualified teachers to improve retention, equipment, and renovations.	Program pays a per-child rate to supplement the state child care subsidy and parent copayments collected for each child or an agreed upon portion of staff salaries. Supplemental funds for additional costs of meeting the HSPS are common, such as CDA training, teacher bonuses, and equipment.	Financial support is limited. Per-child supplements to state subsidies and parent copayments are minimal. Purchase of equipment and supplies is limited.
Technical Assistance and Training	Support from Early Head Start is intensive. Usually includes weekly visits to the provider, CDA training, individualized staff development plans, assistance with curriculum development, and financial incentives to encourage compliance with the HSPPS.	Support from Early Head Start is intensive, but usually includes fewer financial incentives.	Regular technical assistance and support is provided, but provision of CDA training, equipment, and supplies is limited.
Safeguards Against Interruptions in Care	Families receive services as long as they are eligible for Early Head Start. Continuity of children's child care placements is not jeopardized by temporary loss of eligibility for state child care subsidies.	To receive services, families must be eligible for Early Head Start services and state child care subsidies. Continuity of children's child care placements is jeopardized by temporary loss of eligibility for state child care subsidies, but partnerships can often maintain the placements in the short term.	To receive services, families must be eligible for Early Head Start services and state child care subsidies. When families lose their child care subsidy and cannot afford to pay for the care, children often lose their child care slots.

SOURCE: Focus groups and individual interviews with Early Head Start staff, child care partners, Head Start and Child Care Bureau staff and technical assistance providers, and others staff from other community programs that support the partnerships.

HSPPS = Head Start Program Performance Standards

CDA = Child Development Associate credential

partnership are decided. Partnership agreements vary in formality and level of detail. Typical partnership agreements describe the resources that the Early Head Start program will provide to the child care partner and the standards that the provider must meet.

Technical Assistance and Support. Early Head Start programs usually provide child care partners with technical assistance and support during regular visits—which can be as often as weekly. Provider liaisons assess quality and adherence to the HSPPS, work on goal plans with providers, offer feedback about the quality of care observed, model developmentally appropriate caregiving, provide hands-on training, and help providers with

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curriculum and lesson planning. Liaisons sometimes bring in outside experts—such as nutrition, health, or disabilities specialists—to support the child care partners.

Teacher Training. Early Head Start programs help child care teachers obtain a CDA credential (if they do not already have one or a higher degree) and participate in other training. In a typical partnership, the provider liaison works with each teacher to develop an individual staff development plan that identifies training needs and describes plans for meeting those needs. Programs help teachers access CDA classes and other training by providing them directly or helping teachers enroll in community colleges or agency-provided courses. Programs tailor training to providers' needs by offering training during evenings and on weekends, providing substitute teachers to relieve teachers of their duties during training, providing CDA courses in Spanish, and providing CDA training through independent study.

Financing the Partnerships. State child care subsidies are not sufficient to cover the cost of child care that meets the HSPPS quality standards. Early Head Start grants usually do not provide enough funding to cover the comprehensive child and family services that the standards require and full-day, full-year child care. Early Head Start-child care partnerships must draw on multiple funding sources to meet families' child care needs and comply with the HSPPS. The following funding sources are typically used:

- **State Subsidies.** Most partnerships studied combine state child care subsidy funds and Early Head Start funds to pay for child care. Typically, a provider agrees to collect the state child care subsidy payment, and in some cases a co-payment from parents. In recognition of the additional costs associated with the HSPPS, the program provides enhancement funds to supplement the subsidy.

- **Other State Sources.** Some states draw on other sources to fund the partnerships. For example, Kansas uses Temporary Assistance for Needy Families (TANF) transfers to fund Early Head Start services provided through partnerships with community child care providers. Missouri funds a similar program with TANF transfers and revenue from taxes on gambling. Nebraska has used a portion of its CCDF infant-toddler set-aside to fund technical assistance partnerships.

- **Private Sources.** Partnerships received limited funding from private sources. Some used private funds to pay for a training component or to temporarily cover child care costs when families lost eligibility for state subsidies. However, none relied on private sources for a significant portion of their funding.

Emerging Themes and Next Steps

The experiences of Early Head Start programs and child care providers in developing and sustaining their partnerships can provide valuable insights for others who seek to implement similar collaborative community strategies to help low-income families with infants and toddlers find and pay for good-quality child care. Staff of the Early Head Start-child care partnerships we studied were able to point to progress in a number of specific areas. While not achieved in all of the partnerships we examined, the successes identified here illustrate the potential of partnerships to improve low-income families' access to good-quality infant-toddler care.

- **Improving quality**, as measured by reduced child-teacher ratios and group sizes, enhanced professional development of child care teachers, more developmentally appropriate practices, greater continuity of care, licensing of informal providers, and improved care for non-Early Head Start children.
- **Expanding supply and improving access** through creating new infant-toddler slots, providing an organized system for helping low-income families find and pay for good-quality care, and providing bus transportation if necessary.
- **Getting more resources for child care providers** in the form of funds, developmentally appropriate toys and equipment, and technical assistance and support.
- **Increased community collaboration**, either in the form of new relationships with community agencies or movement toward a comprehensive system of support for child care providers.
- **Building community awareness of early childhood issues**, with emphasis on the importance of good-quality infant-toddler child care and the resources required to provide such care.

Our first year's research also uncovered enduring challenges that continue to confront the partnerships. The experiences of the partnerships we studied indicate the types of challenges similar initiatives in other communities may face. Among these are:

- **Improving quality and complying with the performance standards**, especially when there were significant differences between the state licensing requirements and the performance standards or differences in the philosophy and organizational cultures of partners. High teacher turnover in some communities made obtaining CDA credentials for all teachers challenging.

The cost of improving quality and complying with the performance standards was also a barrier for some partnerships.

- **Achieving and maintaining continuity of care** in the context of child care staff turnover, subsidy eligibility issues, and transitions out of Early Head Start
- **Matching child care arrangements to families' needs**, including the need for care during nonstandard work hours and conveniently located care.
- **Staffing issues,** including staff supervision across partners and maintaining high morale among provider liaisons.

In the next phase of the study, we will develop in-depth case studies of collaborative infant-toddler child care initiatives in three diverse communities. We will include Early Head Start-child care partnerships, as well as other community-based initiatives and partnerships. Through these case studies, we expect to explore the emerging themes described in this interim report in more depth and to identify new themes. Based on these themes, we will formulate operational lessons that can inform the decisions of a wide range of policymakers and program operators as they seek to help low-income families access good-quality child care for their infants and toddlers.

CHAPTER I

INTRODUCTION

In the wake of welfare reform, low-income families face significant child care challenges. Increasing proportions of mothers of young children have entered the workforce. In 1997, 55 percent of mothers with a child younger than age 3 worked; 73 percent of the infants and toddlers in these families were cared for by someone other than a parent while their mother was working (Ehrle et al. 2001). Nevertheless, many low-income families have difficulty arranging, paying for, and sustaining the continuity of child care, especially for their infants and toddlers. Infant-toddler child care is scarce in most communities. Many low-income families lack information about how to arrange infant-toddler child care, and even with the increased availability of child care subsidies, many families face difficulties paying for care.

The quality of child care is a crucial influence on the well-being of infants and toddlers. Extensive research has shown that variations in quality are associated with a broad range of child outcomes across a wide age spectrum (Love et al. 1996) and for infant-toddler care in particular (Love et al. 2000). Good-quality child care can influence positively the developmental outcomes of infants and toddlers, whereas low-quality settings may impede their development. However, finding good-quality care—child care in a safe, healthy environment that meets professional standards for good care and promotes healthy child development—can be especially challenging for low-income families with infants and toddlers.

To address the increasing child care needs of low-income families, federal and state governments have responded in recent years with increased funding for child care and special quality initiatives, some of which are designed specifically to address the unique challenges of infant and toddler care. For example, the Child Care and Development Fund (CCDF) increased federal funding for child care, gave states more flexibility in spending the funds, and set aside funds for quality improvement. In addition, Head Start, Early Head Start, and state-funded prekindergarten programs have expanded.

Nevertheless, child care and child development service systems are often fragmented, as are efforts to improve child care quality. To increase coordination across systems, policymakers and program operators have begun to collaborate in addressing the child care and child development needs of young children whose parents are working. At the state and local levels, many efforts are underway to increase collaboration, develop partnerships, and coordinate services (Kagan et al. 2000; Ochshorn 2000; and Schumacher et al. 2001). These efforts, however, have not necessarily focused on infant-toddler child care.

In fall 2000, ZERO TO THREE and Mathematica Policy Research, Inc. (MPR) obtained funding from the Child Care Bureau of the U.S. Department of Health and Human Services (DHHS) to conduct an in-depth study of collaborative community initiatives designed to improve low-income families' access to good-quality *infant-toddler* child care. This interim report describes what we have learned in the study's first year about promising strategies for building community collaborations and partnerships, as well as preliminary operational themes that may be helpful for programs, communities, and state and federal policymakers who seek to develop, implement, and support partnership strategies. Because Early Head Start has been in the forefront of efforts to promote the development of community partnerships—especially those with child care providers—to help meet the unique needs of families with infants and toddlers, the report examines these Early Head Start-child care partnerships in detail. A comprehensive report of the study's findings, including lessons for policymakers and program operators derived from the experiences of child care partnerships and other collaborative child care initiatives, will be completed in fall 2002. In the rest of this chapter, we lay out the policy context for studying strategies to improve infant-toddler child care for low-income families, review the study's research questions, and provide a guide to the report.

THE POLICY CONTEXT

Recent efforts to improve infant-toddler child care for low-income families have occurred within a context of fundamental changes in the nation's social service systems. Some of these changes have had a dramatic effect on the needs of low-income families with infants and toddlers and the resources available to meet those needs. To set the stage for later analysis of partnerships, five aspects of the policy context in which they have developed must be understood: (1) the supply and quality of infant-toddler child care, (2) welfare reform, (3) increased funding to help low-income families pay for child care, (4) increased recognition of the importance of early childhood development, and (5) increased emphasis on collaboration and partnerships to integrate fragmented service systems.

Supply and Quality of Infant-Toddler Child Care

Previous research indicates that many low-income parents of infants and toddlers have difficulty finding child care. Licensed and regulated child care is less available for infants and toddlers than for older children (Fuller and Liang 1996; and Fuller et al. 1997). Low-income families face shortages of regulated child care options in their neighborhoods and lack of

transportation to child care providers outside their immediate neighborhoods (Fuller et al. 2000; Lesser 2000; and Meyers 2001). Chronic shortages also exist for children with special needs or who are sick (Collins et al. 2000). Many low-income mothers work during nonstandard hours, when licensed and regulated care is especially difficult to find (Ross and Paulsell 1998a). Moreover, information about child care options and subsidies to pay for them can be difficult for parents to obtain (Adams et al. 2001; Gong et al. 1999; and Peck and Meyers 2000).

Families are also challenged to find good-quality infant-toddler child care. By most definitions, a large proportion of child care for infants and toddlers is not of good quality (Fenichel et al. 1999). For example, quality as measured by the Infant-Toddler Environment Rating Scale (ITERS; Harms et al. 1990) for center care and the Family Day Care Rating Scale (FDCRS; Harms and Clifford 1989) for family settings consistently has been found to be low across studies of child care quality. These measures rate the quality of care on scales of 1 to 7, in which 3 is described as minimal care, 5 as good, and 7 as excellent. For example, the National Child Care Staffing study found average ITERS scores of 3.17 and 3.57 in centers serving infants and toddlers, respectively (Whitebook et al. 1989). Only 12 percent of the study classrooms exceeded the score of 5 typically associated with "good" classroom practices. Similarly, the more recent Cost, Quality, and Child Outcomes Study (Cost, Quality, and Child Outcomes Study Team 1995) found average ITERS scores to be 3.42, with 40 percent of classrooms scoring below 3.0 and only 8 percent above 5.0. The children from low-income families in the Study of Quality in Family Child Care and Relative Care were in settings that averaged 2.6 on the FDCRS (Kontos et al. 1995).

Welfare Reform

Welfare reform in the context of what has until recently been a strong economy has dramatically increased the child care needs of low-income families. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) ended the Aid to Families with Dependent Children (AFDC) program and established Temporary Assistance for Needy Families (TANF), which imposes work requirements after two years on cash assistance (or less time, at the state's option) and a five-year lifetime limit for most recipients. Some states exempt parents of infants from the work requirements for a short time (typically a year or less); but many do not. Thus, most low-income parents of infants and toddlers need child care while they work or participate in work-related activities.

Increased Funding to Help Low-Income Families Pay for Child Care

PRWORA also consolidated federal funding for child care into a new Child Care and Development Fund (CCDF), which provides increased child care funding for low-income families and gives states more flexibility in spending the funds. PRWORA also requires states to set aside at least four percent of their CCDF funds for quality improvement. These funds have supported such activities as training and education for child care providers, salary increases for teachers who complete college courses, consumer education for parents, and

child care resource and referral systems. In addition, PRWORA authorizes states to transfer funds from their TANF grants to CCDF; in fiscal year 1999, these transfers totaled more than $2 billion (Child Care Bureau 2001c). In addition to child care subsidy funds, in recent years the federal government has expanded Head Start and Early Head Start, and most states now fund some public prekindergarten services (Mitchell et al. 1998).

Despite increases in funding for child care subsidies, not all eligible low-income families are able to obtain them. The National Study of Child Care for Low-Income Families found that 12 of the 17 states studied were unable to provide subsidies to all eligible families who requested them (Collins et al. 2000). Moreover, recent evidence on low take-up rates and rapid turnover within the subsidy system and emerging information on the complexity of child care subsidy administration procedures from parents' perspectives suggest that low-income families often face substantial challenges in accessing and maintaining child care subsidies (Peck and Meyers 2000).

Increased Recognition of the Importance of Early Childhood Development

Increased recognition of the importance of early childhood development has led to an increased awareness of the need for good-quality child care for infants and toddlers and the potential for early care and development services to improve children's readiness for school. Recent research has shown that human development during the early years of life is rapid and extensive and vulnerable to environmental influences (Shonkoff and Phillips 2000). Moreover, early development has a long-lasting effect on children's cognitive, behavioral, and physical development (Carnegie Corporation of New York 1994). National attention focused on early brain development in spring 1997, when the White House convened the Conference on Early Childhood Development and Learning and special editions of national news magazines featured articles on infant brain development.

Increased Emphasis on Collaborative Efforts to Integrate Fragmented Service Systems

Although public spending on child care and early childhood development programs has increased dramatically in recent years, and subsidy funding streams have been consolidated, service delivery systems often are fragmented. For example, even though they serve similar populations of children and families, low-income child care programs, Head Start and Early Head Start, and public prekindergarten programs are funded by distinct funding streams and are governed by different—sometimes conflicting—sets of regulations and guidelines.

In recent years, several initiatives have been launched to facilitate collaboration across service delivery systems. For example, in 1997, the Head Start Bureau established collaboration offices in all states to facilitate linkages with state prekindergarten and child care programs. In late 1998, the Child Care and Head Start Bureaus launched a new training and technical assistance initiative—Quality in Linking Together: Early Education Partnerships (QUILT)—to help Head Start programs and child care providers develop

partnerships. Other initiatives have focused on developing partnerships between Head Start, child care, and public school systems (Ochshorn 2000).

Research Questions

The study is designed to identify a range of strategies that communities employ to increase the supply and enhance the quality of infant-toddler child care accessible to low-income families. The research questions that guide our study address five broad themes: (1) quality, (2) affordability, (3) state policy, (4) barriers faced by families, and (5) challenges to collaboration. Table I.1 lists these themes, along with the specific research topics for Year One. Under the themes of quality and affordability, we seek to learn about community strategies that have been implemented to help low-income families access good-quality child care and pay for it. In particular, we seek information about collaborative community partnerships that address both quality and affordability issues. Under the state-policy theme, we seek to learn how state policies and child care funding affect community collaborative efforts. We also seek information about barriers faced by families, especially any new barriers that have surfaced as a result of welfare reform. Finally, we seek to understand the challenges to implementing collaborative partnerships in communities.

Overview of the Report

The rest of this report describes in detail what we learned in the study's first year about initiatives to improve infant-toddler child care for low-income families. Chapter II provides an overview of our research methods and data sources in Year One. Chapter III describes barriers faced by low-income families who need infant-toddler child care. Chapter IV provides an overview of federal, state, and community initiatives designed to increase access to good-quality infant-toddler care. In Chapters V, VI, and VII, we document in detail the Early Head Start-child care partnerships we examined—including strategies for building the partnerships, arrangements for financing the partnerships, and other community initiatives that support the partnerships. Chapter VIII provides a preliminary report on the main successes and challenges of the partnerships we studied in Year One. Chapter IX describes preliminary operational themes about designing, implementing, and supporting child care partnerships derived from the partnerships' experiences.

TABLE I.1

RESEARCH QUESTIONS AND TOPICS

Research Questions	Specific Research Topics for Year One
Quality	
What community strategies have been implemented to improve the quality of infant-toddler child care used by low-income families? What are the processes of collaboration, and how long does it take to form partnerships and address issues related to the quality of infant-toddler child care?	• Strategies developed for improving the quality of infant and toddler care in the community • Extent to which quality strategies are linked to collaborative community partnerships • How the strategies have been implemented (steps, timelines, key players, funding) • Processes of collaboration and steps in forming partnerships • Successes and challenges in implementing the strategies • Lessons for other communities and partnerships
Affordability	
What community strategies have been implemented to help families pay for good-quality child care? How do child care and other service providers navigate state child care subsidy systems, help families avoid interruptions in child care caused by interruptions in subsidy payments, and help families pay for good-quality care when they cannot pay the difference between the subsidy and the cost of care?	• Strategies developed for helping families pay for good-quality infant and toddler care • Extent to which affordability strategies are linked to collaborative community partnerships • How the strategies interact with the state child care subsidy system, and how they address interruptions in subsidy eligibility • How the strategies have been implemented (steps, timelines, key players, funding) • Successes and challenges in implementing the strategies • Lessons for other communities and partnerships
State Policy	
How have communities worked with states to access funding and develop policies that address the needs of low-income families with infants and toddlers for affordable, accessible, good-quality child care?	• How state subsidy and other child care policies influence collaborative community partnerships and strategies to help low-income families find and pay for good-quality infant-toddler care • Use of state child care subsidies and other state funds by collaborative partnerships • How state funds are combined with other funding sources by collaborative partnerships • Community activities to influence state child care policies • Lessons on how states can support collaborative partnerships through funding and policy changes

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TABLE I.1 *(continued)*

Research Questions	Specific Research Topics for Year One
Barriers Families Face	
What barriers do low-income families face in accessing good-quality child care for their infants and toddlers?	• Influence of welfare requirements on low-income families' needs for infant-toddler child care • Supply of child care for infants and toddlers • Cost of child care for infants and toddlers • Nature and availability of child care subsidies for low-income parents of infants and toddlers • Quality of child care for infants and toddlers • Availability of information and resources to help parents arrange good-quality child care for their infants and toddlers • Aspects of the community context that influence parents' child care needs (for example, work shifts of parents, availability of public transportation, location of child care providers)
Challenges to Collaboration	
What challenges do community child care providers and other community service providers serving low-income families with infants and toddlers face in implementing collaborative initiatives and partnerships to increase families' access to good-quality infant-toddler child care?	• Nature of existing collaborative community partnerships that aim to help low-income families access good-quality child care for their infants and toddlers • Key members of existing collaborative partnerships and their roles • Strengths and weaknesses of existing collaborative partnerships • State and federal policies that pose challenges to collaborative partnerships • Community characteristics that pose challenges to collaborative partnerships • Lessons for federal and state policymakers and program administrators and communities on how they can support collaborative partnerships

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CHAPTER II

DATA SOURCES AND METHODS

Because collaborative community strategies for addressing the child care needs of low-income families with infants and toddlers have not been well documented in other research, this study is exploratory in nature. Using an iterative process to identify data sources and collect data for the study, we began by reviewing recent literature on the barriers faced by low-income families who need infant-toddler child care and the strategies that have been implemented to address these barriers. We then conducted interviews with a range of government officials, child care researchers, and other experts and conducted focus groups with child care providers, Early Head Start staff, and others who serve families with infants and toddlers. Based on this initial round of data collection, we identified promising, collaborative community partnerships that are working to address comprehensively the barriers faced by families. We interviewed key players in these partnerships. In some communities, we also interviewed other community informants who are knowledgeable about the partnerships or who participate in them. The rest of this chapter describes in detail our data sources, data collection activities, and analytic methods.

DATA SOURCES

Because this study is exploratory in nature—seeking to identify and understand promising collaborative strategies, rather than quantify their prevalence or test their effectiveness—we relied primarily on qualitative data. These types of data are well suited to addressing the research questions and topics described in Chapter I. For example, a qualitative approach is advantageous for collecting detailed information about diverse strategies for developing collaborative partnerships; identifying key implementation issues associated with the strategies; and discerning patterns of challenges, successes, and lessons that emerge from the strategies. We used three main data sources for this study: (1) recent literature, (2) focus groups, and (3) telephone interviews.

RECENT LITERATURE

We reviewed and synthesized findings from recent studies and reports on the barriers low-income families face in arranging and paying for good-quality infant-toddler child care, strategies that have been implemented for addressing the barriers, and implementation challenges associated with the strategies that were identified. Because welfare reform has dramatically increased the child care needs of low-income families and increased child care funding, we concentrated on barriers and strategies that have emerged since implementation of the welfare reforms of 1996. In addition, because we found that barriers faced by families are relatively well documented in the literature, we focused greater effort on identifying strategies than on identifying barriers.

We began the literature review for this study by building on literature reviews conducted by MPR for the Study of Infant Care Under Welfare Reform (Ross and Kisker 2000), and the Role of Child Care for Low-Income Families' Labor Force Participation research project (Ross 1998; Ross and Paulsell 1998a; and Ross and Paulsell 1998b). We then reviewed other bibliographies and conducted database and Internet searches to identify additional literature to be reviewed. Although we identified and reviewed most of the literature we used in the study's initial phase, we continued adding new literature to our review throughout the study.

FOCUS GROUPS

We conducted a series of seven focus groups with a diverse set of Early Head Start staff, child care providers, and technical assistance and training providers from across the country (Table II.1). The size of the focus groups ranged from 8 to 14 participants. An initial focus group was conducted at ZERO TO THREE's 15th National Training Institute in Washington, DC, in December 2000. Six focus groups were conducted in January 2001, at the Fifth Annual Head Start and Child Care Birth-To-Three Institute in Washington, DC. We selected these venues for conducting our focus groups because both drew participants from across the country. Moreover, participants at both conferences were likely to serve low-income families with infants and toddlers and to be highly involved in community efforts to help these families access good-quality, infant-toddler child care.

Due to the exploratory nature of our study, we sought to recruit motivated participants who were involved in local community efforts, rather than to identify a representative sample of participants. However, we did attempt to recruit a balance of participants from urban and rural communities, states with a range of policies regarding work requirements for parents of infants, and communities that served families for whom English was not a first language. In addition, focus groups included participants from 26 states and the District of Columbia (Table II.1).

We recruited focus group participants by sending an invitation to participate by letter and e-mail message. These invitations provided a general overview of the study and the topics that would be covered during the focus group discussion. Invitees were asked to complete a response form and return it by fax to ZERO TO THREE if they wished to

TABLE II.1

KEY CHARACTERISTICS OF FOCUS GROUP PARTICIPANTS

Key Characteristics	FG 1	FG 2	FG 3	FG 4	FG 5	FG 6	FG 7	Total
Affiliation								
Early Head Start	4	11	7	5	6	8	0	41
Child Care Provider	8	0	3	3	0	3	0	17
Training/TA Provider	2	2	0	0	2	2	8	16
Key Characteristics								
Service area includes urban community	NA	13	10	3	5	10	NA	41
Service area includes rural community	NA	1	1	8	8	5	NA	23
State welfare rules require parents of infants to work and requirements strictly enforced	NA	9	5	5	5	7	NA	24
Serves families for whom English is not first language	NA	9	10	4	0	5	NA	28
State								
California	2	1	3	0	1	1	1	9
Colorado	1	0	0	0	0	0	1	3
Connecticut	0	0	1	0	0	0	0	1
Delaware	1	0	0	0	0	0	0	1
District of Columbia	1	0	0	0	0	0	0	1
Florida	0	1	0	3	0	1	0	5
Illinois	1	1	0	0	0	0	1	3
Indiana	0	0	0	0	1	2	0	3
Iowa	0	5	0	0	0	0	0	5
Kansas	0	0	2	1	0	0	0	3

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TABLE II.1 (*continued*)

Key Characteristics	FG 1	FG 2	FG 3	FG 4	FG 5	FG 6	FG 7	Total
Maryland	0	0	0	0	1	0	0	1
Massachusetts	3	0	2	0	1	0	0	6
Minnesota	1	0	0	0	0	0	0	1
Missouri	1	1	0	1	2	1	1	7
Nebraska	0	2	0	0	1	1	0	4
New Hampshire	1	0	0	0	0	0	0	1
New York	0	0	0	1	0	0	1	2
North Carolina	1	0	0	0	0	0	0	1
Ohio	0	0	0	1	0	2	0	3
Oklahoma	0	1	0	0	0	0	0	1
Oregon	0	1	0	0	0	0	0	1
Pennsylvania	0	0	0	0	0	0	1	1
Texas	0	0	0	0	0	0	1	1
Washington	0	0	1	0	0	2	1	4
Wisconsin	0	0	0	0	1	3	0	4
Virginia	0	0	1	0	0	0	0	1
Vermont	0	0	0	1	0	0	0	1
Total Participants	**14**	**13**	**10**	**8**	**8**	**13**	**8**	**74**

FG = Focus Group.
NA = Not Available.

NOTE: Focus Group 1 was conducted at the ZERO TO THREE's 15th National Training Institute in Washington, DC in December 2000. Because we had a smaller pool of potential recruits to draw from and planned to hold only one focus group at the training conference, we did not ask participants to provide information about their community and client population when we recruited them. Focus Groups 2–7 were conducted at the Fifth Annual Head Start and Child Care Birth-To-Three Institute in Washington, DC in January 2001. Participants in Focus Group 7 were Senior Early Childhood Specialists (SECAs) employed by ZERO TO THREE. SECAs are located in the ACF regional offices and provide technical assistance to Early Head Start programs. They are knowledgeable about child care and other infant-toddler initiatives that have been implemented in their service areas.

participate. Focus group participants did not receive payment for their participation in the focus groups, although they did receive several ZERO TO THREE publications on infants and toddlers as thank-you gifts for their participation.

For the focus group held at ZERO TO THREE's 15th Annual Training conference, we extended invitations to all conference registrants who listed their occupation as early childhood educator; their position as administrator, supervisory/manager, or direct service staff; and their work setting as child care center, family child care home, or Early Head Start program. Of 106 registrants who met these criteria, 14 participated in the focus group discussion.

For the focus groups held at the Birth-To-Three Institute in January 2001, we extended invitations to approximately 370 registrants who had submitted their registration information at least one month prior to the conference and who had provided e-mail addresses on their registration forms. Approximately 70 registrants responded to the invitation; of those, about three-fourths attended one of five focus group sessions.

A sixth focus group discussion was held at the Birth-To-Three Institute for Senior Early Childhood Associates (SECAs) employed by ZERO TO THREE and housed in the ACF regional offices. The SECAs provide technical assistance to Early Head Start programs and are knowledgeable about child care services, other infant-toddler initiatives, and state child care policy in their regions. Eight of the ten SECAs participated in the focus group discussion.

TELEPHONE INTERVIEWS

We conducted telephone interviews with approximately 80 respondents, beginning with an initial set of 18 interviews with key informants, including federal staff from the Child Care and Head Start Bureaus, technical assistance staff from the Early Head Start National Resource Center and The QUILT (Quality in Linking Together) Project, child care researchers, and other child care policy experts (Table II.2). During these interviews, we discussed barriers faced by families and promising community-level strategies, and we asked for recommendations of initiatives we should study. Based on the results of these interviews, along with our findings from the literature review and focus group discussions, we contacted state-level informants to learn more about initiatives in 16 states and to solicit recommendations of collaborative community partnerships we should investigate further.[1]

[1]Eleven of these key informant and state-level interviews were conducted by MPR senior economist Christine Ross as part of the Child Care Demonstration Planning Project. For this project, Dr. Ross collected information similar to the data collected for this study. She interviewed national child care policy experts and state and local child care officials to learn about child care policy issues and initiatives that warranted further study and research. Our research team used these interviews to identify infant-toddler child care policy issues and promising strategies for further investigation.

TABLE II.2

CHARACTERISTICS OF TELEPHONE INTERVIEW PARTICIPANTS
KEY AND STATE-LEVEL INFORMANTS

Informants	Federal Staff	State Officials	T/TA Staff	Child Care Researchers	Child Care Policy Experts	State CCR&R Staff	Other	Total
Key Informants	3	0	4	6	5	0	0	18
State-Level Informants								
California	1	2	2	2	0	1	1	9
Colorado	0	0	2	0	0	0	0	2
Delaware	1	0	0	0	0	0	0	1
Florida	0	0	0	1	0	0	0	1
Illinois	1	0	0	0	0	0	0	1
Iowa	1	0	1	1	0	0	0	3
Kansas	1	0	1	1	0	1	0	4
Maine	0	0	1	0	0	0	0	1
Maryland	1	0	0	0	0	0	0	1
Massachusetts	0	0	1	0	0	0	0	1
Missouri	1	0	1	1	0	0	0	3
Nebraska	1	0	1	1	0	0	0	3
North Carolina	0	1	0	0	0	0	0	1
Utah	0	0	2	0	0	0	0	2
Washington	0	0	0	0	0	1	0	1
Wisconsin	0	1	0	1	0	0	1	3
Total Interviews	**7**	**4**	**10**	**11**	**5**	**3**	**2**	**42**

NOTE: Some columns do not add up to the number of total interviews, because we interviewed some informants about more than one state.

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We then conducted interviews with 39 community-level informants representing 27 communities in 15 states (Table II.3). Most respondents for these interviews were key staff from lead agencies in the community initiatives identified. Where appropriate and possible, we also conducted interviews with other community partners that played key roles in the initiatives. This component of the study will be expanded considerably in the study's second year, as we conduct site visits and develop in-depth case studies of collaborative community partnerships in three communities.

Approximately two-thirds of these community-level informants were Early Head Start program staff. We found that Early Head Start-child care partnership initiatives implemented a variety of strategies to address comprehensively the barriers low-income families confront in finding and paying for good-quality child care for their infants and toddlers. Although Early Head Start serves only a small portion of low-income families who need infant-toddler child care, we believe that Early Head Start programs offer an effective point of entry into community strategies that address infant-toddler child care issues. The network of Early Head Start programs is large (more than 600 nationwide). In addition, because service organizations that focus on low-income families continually need funding to support their activities, we expect that a large proportion of the pool of organizations devoted to improving child care for infants and toddlers have applied for and received Early Head Start funding. Moreover, TANF work requirements make it likely that virtually all Early Head Start program must grapple with finding effective ways to address the child care needs of enrolled families.

DATA COLLECTION

This section describes in detail the data collection procedures we followed in Year One of the study, including discussion guides for focus groups and telephone interviews, procedures for conducting focus group discussions and telephone interviews, and steps taken to ensure data quality.

Discussion Guides

We developed discussion guides for conducting all of our focus groups and telephone interviews (Tables A.1–A.4). We organized our discussion guides according to our main research questions. Each guide was tested with an initial set of respondents. After these initial discussions, all members of the research team reviewed discussion summaries, discussed the flow of the interviews and any problems noted, and made decisions about changes to the guides. In addition, we customized the guides for each type of respondent, particularly for community-level respondents. While we followed the guides fairly closely, we modified or added questions as necessary and appropriate for particular respondents.

Separate discussion guides were developed for each set of respondents identified in the previous section. We used results of our literature synthesis to draft an initial discussion guide for telephone interviews with key informants (Table A.1). Next, we used the results of

TABLE II.3

CHARACTERISTICS OF TELEPHONE INTERVIEW PARTICIPANTS
COMMUNITY-LEVEL INFORMANTS

State	EHS Staff	Child Care Provider	Local Government Official	Other	Total
California	0	1	2	0	3
Colorado	1	0	0	0	1
Delaware	1	0	0	0	1
Florida	1	0	1	0	2
Illinois	2	0	1	1	4
Iowa	2	0	0	0	2
Kansas	4	2	0	1	7
Maryland	0	0	1	0	1
Missouri	6	3	0	0	9
Nebraska	2	0	0	0	2
North Carolina	0	0	0	1	1
Pennsylvania	1	0	0	0	1
Vermont	1	0	0	0	1
Washington	2	0	0	0	2
Wisconsin	0	2	0	0	2
Total Interviews	**23**	**8**	**5**	**3**	**39**

these interviews and the results of our literature synthesis to draft an initial discussion guide for conducting the focus groups. After conducting one a focus group at ZERO TO THREE's 15th Annual Training Conference, we modified the guide and finalized it (Table A.2). We used the results of our focus group discussions and other data collected to draft a discussion guide for state-level informants (Table A.3). Research team members modified this guide as necessary and appropriate to obtain detailed information about specific strategies for interviews with community-level informants (Table A.4). Research team members reviewed and discussed all guides during weekly team meetings.

Procedures for Conducting Focus Groups and Telephone Interviews

To further ensure consistency across the discussions, all focus groups were conducted by teams of two members of our research team. One researcher led the discussion, and a second researcher took notes, operated a tape recorder, and helped the discussion leader by adding probes and recognizing participants who wanted to speak. Each focus group discussion lasted approximately 1.5 hours. At the start of each focus group, the lead

researcher introduced herself and her partner, provided an overview of the research project and the purpose of the focus group, provided assurances of confidentiality, and reviewed the procedures she would follow in moderating the discussion (see Table A.2).

We conducted an initial set of each round of telephone interviews in teams of two. One research led the interview. The second researcher took notes and wrote up an interview summary. The research team discussed the interview process on a weekly basis during team meetings. Telephone interviews typically lasted 45 minutes to 1 hour. At the start of each telephone interview, the lead research introduced herself and her partner, described the research project and purpose of the interview, and provided assurances about confidentiality.

Ensuring Data Quality

We took several steps to ensure the quality of our data. First, to ensure consistency in information obtained across respondents, we used discussion guides that were based on a defined set of topics for conducting all focus groups and telephone interviews. In addition, all research team members were trained to use the discussion guides. During these training sessions (via conference calls), we reviewed all questions contained in the discussion guides and the results of initial tests of the guides. We also established common procedures for conducting the focus groups and telephone interviews, protecting the confidentiality of respondents, and using the guidelines in writing summaries of the discussions.

As described above, all focus groups and initial telephone interviews were conducted in teams; all focus group discussions were audiotaped. As soon as possible after each discussion, the teams prepared summaries following a predetermined format, to ensure that they remembered details clearly and could follow up promptly, if need be, on any gaps in the information collected. Research team members reviewed each of these summaries and discussed them during weekly research team meetings.

Data Analysis

In Year One, this study required the collection and analysis of a large amount of qualitative data from a variety of sources and respondents. Our analytic approach focused on synthesizing and categorizing information from the literature synthesis, focus group discussions, and telephone interviews according to topic areas based on our main research questions. This synthesis was used to identify promising strategies, emerging themes about successes and challenges of the collaborative community partnerships we examined, and preliminary operational themes that may be helpful for policymakers, program administrators, communities, and new partnerships.

Literature Synthesis

After selecting and reviewing recent literature, we created a series of data matrices to organize and categorize the information extracted according to our research questions. In these matrices, we summarized key dimensions of the studies we selected—such as study methodology, sample design, and time period covered; organized barriers identified in the literatures into categories; categorized strategies for addressing the barriers low-income families face in arranging good-quality infant-toddler child care; and categorized challenges to community collaboration.

We used these data matrices to synthesize key findings across studies. For example, we used them to compare types of barriers identified across studies and communities. We also used the matrices to compare barriers and strategies identified across data sources. For example, we compared the barriers identified in recent literature with barriers identified by focus group participants and telephone interview respondents.

Individual and Group Discussion Summaries

Following each focus group and telephone interview, we created a detailed summary of the discussion according to a predetermined format that followed the organization of the discussion guides. This process of systematically organizing and categorizing the information facilitated the identification of themes, patterns, and new issues. The summaries facilitated comparisons across communities and initiatives of families' needs, barriers faced, features of child care markets, strategies to address barriers, and processes of collaboration. In addition, the summaries enabled us to compare the responses of diverse informants within particular states and communities.

Data Displays

We used the focus group and interview summaries to create data displays—primarily matrices—to facilitate an understanding of barriers and strategies identified both within and across communities. The data displays were descriptive as well as explanatory. Descriptive displays summarized information about a single set of variables, such as barriers to finding good-quality infant-toddler care. Explanatory displays organized data so that relationships among variables could be more readily detected—for example, barriers and strategies implemented across and within communities.

The next step was to synthesize data across all sources. We developed categories of strategies identified in recent literature, focus group discussions, or telephone interviews. Then, we grouped all of the initiatives identified in our data under these categories. We evaluated them according to the extent to which they focused on the target population and the multiple barriers identified in our conceptual model, and based on whether they were likely to have useful lessons for others seeking to address these barriers.

We found that few of the strategies we had identified focused on the target population of low-income families with infant and toddlers *and* worked to address comprehensively the multiple barriers that families faced (see Chapter 4 for a more detailed discussion of strategies). Only the partnership strategies met these criteria; and, of these, not all had been in place long enough to yield useful lessons for others. Base on this analysis, we created a final set of data displays to categorize and synthesize the data we collected on partnership strategies.

Because only the partnership strategies met our criteria, we focused on them in the Year One report, with an emphasis on identifying preliminary operational themes for others who seek to implement or support similar strategies. We used much of the data collected on other strategies to demonstrate ways in which other supply, quality, and funding initiatives contributed to collaborative community partnership efforts. We also used this data to provide important background and context about the range of strategies to improve access to good-quality infant-toddler care that have been implemented in recent years.

CHAPTER III

BARRIERS FACED BY LOW-INCOME FAMILIES WHO NEED INFANT-TODDLER CARE

Under PRWORA, parents receiving TANF cash assistance face increasing work participation requirements. Parents of young children are not excused from these requirements; many states require single parents of children under age 1 to work (Kirby, Ross, and Puffer 2001). The growing number of low- and moderate-income parents in the workforce who have very young children has led to a critical challenge: finding good-quality, affordable child care for children under age 3.

The barriers to finding and maintaining good-quality child care for children under age 3 range from insufficient supply during nontraditional work hours to high costs and difficulty accessing and maintaining state child care subsidies. Child care costs, especially the costs of infant-toddler care, place a substantial financial burden on working families. Among those who cannot or do not obtain subsidies to help pay for child care, many must resort to placing their children in lower-cost arrangements, with the accompanying risk of lower-quality service.

In this chapter, we describe the insufficient supply of infant-toddler child care, the shortage of good-quality infant-toddler care, the high cost of care, difficulties accessing and maintaining state child care subsidies, and difficulties accessing consumer information about child care availability and quality. In each area, we draw on two main sources of information about the barriers faced by low-income families who need infant-toddler care: (1) key findings from a review of recent literature on the barriers that low-income families face in arranging good-quality infant-toddler child care, with a special focus on new barriers that have surfaced since the welfare reforms of 1996; and (2) first-hand information about barriers to arranging infant-toddler child care from child care providers and Early Head Start staff who participated in a series of eight focus groups conducted in late 2000 and early 2001.

Insufficient Supply of Infant-Toddler Care

Previous research indicates that the supply of infant-toddler child care is inadequate in many communities when compared to increasing demand (Nadel 1998). Licensed and regulated care, in particular, is less available for infants and toddlers than for older children (Fuller and Liang 1996; and Fuller et al. 1997). The supply of infant care is so limited that parents often face long waiting lists for slots in centers (Blank et al. 2000). In low-income neighborhoods, regulated child care options are in short supply; the largest gaps between known supply and demand in these neighborhoods are for infant care and care for school-aged children (Fuller et al. 2000; General Accounting Office 1997; and Lesser 2000). Many low-income parents rely on relatives to provide child care, in part because regulated arrangements are in short supply and in part because of parents' preferences (Ehrle et al. 2001; and Porter 1998).

In focus groups that we conducted with Early Head Start and child care staff, participants reported high demand for infant-toddler child care in their communities, especially since the 1996 welfare legislation was passed. Program staff from Wisconsin reported that, despite the availability of state child care subsidies for low-income families in their community, many families with babies under age 1 cannot obtain child care because infant slots are not available. Moreover, waiting lists often span two to three years for the few licensed infant slots available in the community.

According to focus group participants, the high cost of providing infant-toddler care—coupled with low child care subsidy reimbursement rates for providers—contributes to the limited supply of infant-toddler care in many communities. Because most states require lower child-caregiver ratios and smaller group sizes for infants and toddlers, providing infant-toddler child care is more expensive than care for older children. Focus group participants, however, reported that the higher cost of providing infant-toddler care often is not reflected in provider reimbursement rates. Before PRWORA was enacted, states were required to complete market rate surveys of child care providers every two years, and to set payment rates at the 75th percentile (a payment rate high enough to encompass 75 percent of providers or slots in the community) (Greenberg 1999). Under PRWORA, this market rate requirement was eliminated. States are not required to pay for child care at the 75th percentile, and many states do not. Thus, providers who accept state child care subsidies may not receive reimbursement for the full cost of providing care. Focus group participants from communities in Colorado and California reported that some providers in their communities have reduced or eliminated the number of infant-toddler slots they offer because they cannot cover their costs for these slots.

Low-income families often find it harder than other families to gain access to regulated child care because they are more likely to require features of care that are in particularly short supply, such as part-time care, care during nontraditional work hours, care for children with special needs, and care for sick children. The following sections summarize what we learned from recent literature and focus group discussions about shortages of these types of care.

Part-Time Child Care

Focus group participants reported that finding part-time care for infants and toddlers is often a challenge for families. For example, program staff from communities in Minnesota, Colorado, and Iowa said that because demand for infant-toddler care in their communities is so high, infant-toddler providers can fill their slots without accepting children who need part-time care. Moreover, providers can cover more of their costs when they enroll children for full-time care, rather than accepting children for part-time enrollment.

Limited Supply of Care During Nontraditional Work Hours

The difficulty most working parents have in finding affordable, high-quality infant-toddler child care during regular business hours is magnified when they need child care during nontraditional work shifts. Previous research suggests that a high proportion of low-income, working parents have jobs with nontraditional shifts that include early morning, weekend, holiday, evening, overnight, rotating, or overtime hours (more hours than a traditional eight-hour work shift). For example, a study by Hofferth (1995) found that one-third of working-poor parents work on weekends, and almost half of all working-poor parents work a rotating or changing schedule. Nevertheless, child care consumers report chronic shortages in the supply of child care during non-traditional hours and holidays (Collins et al. 2000).

Child care by relatives and friends—kith and kin care—provides options for some parents who work during nontraditional hours. Evidence suggests that parents' reliance on care by relatives and friends may be due in part to the flexible hours of these providers, who are more willing to provide care during nontraditional work hours (Porter 1998). However, parents who need care during nontraditional work hours, but do not have relatives or friends who can provide it, have fewer child care options.

Focus group participants reported a growing need in their communities for infant-toddler care during nontraditional work hours. Providers from several communities in Massachusetts, California, and Washington, DC, described a large population of parents with infants and toddlers working at jobs that require nontraditional work hours—from jobs in mills and factories that operate 24 hours a day, 7 days a week to positions in start-up, high-tech companies that demand 80 or more hours a week. A participant from Massachusetts however, reported that her community has little, if any, regulated infant-toddler child care available for parents who work nontraditional shifts. Focus group participants from Kansas and Florida reported that parents who work variable or rotating shifts (that change from week to week or month to month) face difficulties in finding stable infant-toddler care. A participant from New Hampshire reported that family child care homes in her community provide most of the care available during nontraditional hours. In New Hampshire, however, these providers must obtain a separate license to care for children after 7:00 P.M. This extra requirement may create a disincentive for some providers who might otherwise have considered providing evening or weekend care.

Shortages of Child Care for Children with Special Needs

The accommodation that must be made for children with special-needs, along with inadequate subsidy reimbursement rates, may deter some child care providers from caring for low-income children who need specialized care. Research has documented the increased risk faced by children in low-income families for a variety of poorer outcomes including learning disabilities, mental retardation, developmental delay, and health impairments (Shonkoff and Phillips 2000). Consequently, children in low-income families may be more likely to need special accommodation within the child care setting and flexibility of attendance to deal with illness-related absences and medical appointments. Nevertheless, child care consumers have reported shortages in the supply of care for children with special needs (Collins et al. 2000). In addition, research suggests that subsidy rates may be too low to cover the higher costs of care for some children with special needs (General Accounting Office 1997).

Focus group participants described difficulties faced by low-income parents in finding special-needs care for their infants and toddlers. Several reported that the overall demand for infant-toddler child care is so great in their communities that some centers can avoid accepting children with special needs. For example, a provider from Colorado stated that parents with special-needs children, especially children with significant disabilities, cannot find infant-toddler child care in her community, even though centers are mandated to provide care to these children. In addition, because resources in most child care centers are limited, some participants reported that centers make a "trade-off" and use their scarce resources to serve more low-income children rather than serve children with special needs, thereby reducing the number of slots they can fill.

Shortages of Child Care for Sick Children

Because low-income families often lack paid family and medical leave that they can use for a sick child, sick-child care for infants and toddlers is critical for supporting employment. However, child care consumers have reported shortages in the supply of sick child care (Collins et al. 2000). According to focus group participants, absences due to children's illnesses can also create financial problems for child care providers. In some states, providers do not receive reimbursements when children are absent. Therefore, if a center enrolls a child who is frequently sick and must stay home, the center loses revenue.

Lack of High-Quality Infant-Toddler Child Care

Finding *good-quality* infant-toddler child care is a major challenge for low-income families. Neuroscientific research has highlighted the importance of children's early experiences, noting that early care and nurture have a decisive, long-lasting impact on how children develop, on their ability to learn, and on their capacity to regulate their own emotions (Fenichel et al. 1999). Furthermore, extensive research has shown that variations in child care quality are associated with a wide variety of child outcomes across a wide age

spectrum (Love et al. 1996) and for infant-toddler care in particular (Love et al. 2000). As defined by many researchers, good-quality child care is care in a safe, healthy environment that meets professional standards and promotes healthy child development. Several sets of professional standards for quality care exist, including the National Association for the Education of Young Children (NAEYC) accreditation criteria, the Head Start Program Performance Standards (Administration for Children and Families 1996), and the guidelines of the American Public Health Association and American Academy of Pediatrics (1992).

Research has shown that a large proportion of child care for infants and toddlers is not of good quality (Fenichel et al. 1999). Studies have found that the majority of infant-toddler classrooms in child care centers, family day care homes, and relative care for infants and toddlers are generally not of good quality (Pungello and Kurtz-Costes 1999). The Profile of Child Care Settings Study (Kisker et al. 1991) found an average group size of 10 for 1-year-old classrooms (compared to the Head Start Performance Stands specification of 8) and an average child-staff ratio of between 6:1 and 7:1 (NAEYC recommends 5:1, and the Head Start standards specify 4:1 for that age group). More than one-third of the centers serving 2-year-olds exceeded the maximum group size recommended (12). Dynamic quality, often measured by the Infant-Toddler Environment Rating Scale (ITERS; Harms et al. 1990) for center care and the Family Day Care Rating Scale (FDCRS; Harms and Clifford 1989) for family settings, has also been found to be minimal, on average. For example, the Cost, Quality, and Child Outcomes Study (Cost, Quality, and Child Outcomes Study Team 1995) found the average infant-toddler quality score to be 3.42 (out of 7), with 40 percent of infant-toddler classrooms scoring below 3.0 (minimal) and only 8 percent above 5.0 (good).

Focus group participants reported that parents in their communities want to find good-quality child care settings for their infants and toddlers. Due to cost and availability, however, often they cannot find good-quality care. According to focus group participants from Wisconsin and Indiana, few centers in their communities offer good-quality infant-toddler care, and those that do have long waiting lists. Moreover, participants reported that many good-quality child care centers do not accept state child care subsidies—with long waiting lists and many families who can pay the full cost of care, the centers do not need to serve families with subsidies. A focus group participant from Oklahoma reported the difficulties of finding good-quality care on tribal reservations. While child care is available in more heavily populated areas, she said that rural areas and outlying districts on the reservations often lack good-quality child care options.

According to focus group participants, high staff turnover in child care settings compounds the challenges associated with improving the quality of child care for infants and toddlers. Child care providers often need additional training to provide good-quality infant-toddler care. However, as one participant from California pointed out, because child care providers frequently leave centers or family child care homes for jobs with higher pay after being trained, providing caregiver training is an ongoing need.

High Cost of Infant-Toddler Care

The high cost of infant-toddler care is a significant barrier for many working families. The cost of child care disproportionately affects low-income families, who often pay a higher percentage of their income for care than middle or upper income families (Southern Institute on Children and Families 2000). Child care expenses are often the second or third largest item in a low-income family's household budget (Administration for Children and Families 1999a).

Regulated child care arrangements are often out of reach for working-poor families if they do not have access to state child care subsidies. According to the U.S. Department of Health and Human Services (DHHS), because of a lack of federal funding, approximately 12 percent of the estimated 15 million children eligible for child care assistance actually received it in fiscal year 1999 (U.S. Department of Health and Human Services 2000).[1] Even those families receiving child care subsidies may find it difficult to afford child care—if providers' rates exceed the state reimbursement level, subsidies are not enough to ensure access (Administration for Children and Families 1999a). In addition, parental choice in the child care system may be restricted by low provider payment rates and high copayment rates (Kirby, Ross and Puffer 2001). Some child care experts believe that low provider reimbursement rates and high co-payment levels lead some parents to choose less-expensive unlicensed arrangements, and they worry about the quality of this type of care (Besharov and Samari 1999).

Difficulties Accessing and Maintaining Subsidies

Although low-income parents may be eligible to receive state child care subsidies, accessing the subsidies can be difficult. Because there is not enough funding available to serve all eligible families, states often prioritize among eligible families, either explicitly or implicitly, to determine which families will receive assistance. For example, a recent study found that despite the growth in subsidy use in most of the 17 states studied, 12 of them were unable to provide child care subsidies to all eligible families who requested them (Collins et al. 2000). Experts have found that state child care subsidy programs cut off eligibility at family income levels far below what federal law allows and what families need (Adams et al. 1998). Moreover, recent studies have found that families on waiting lists for child care assistance cut back their work hours or did not work at all and were more likely to receive public assistance, lose their health insurance, and go into debt (Administration for Children and Families 1999a).

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[1]In fiscal year 1999, state-reported statistics showed that approximately 1.8 million children, on average, received federal child care subsidies each month. This figure is approximately 12 percent of the estimated 15 million children thought to be eligible for the federal subsidy. It is a modest increase compared to fiscal year 1998, when states reported serving approximately 1.5 children per month, on average (U.S. Department of Health and Human Services 2000).

Focus group participants reported that the subsidy application and eligibility redetermination processes in some states can pose significant barriers to finding and maintaining good-quality infant-toddler care arrangements. Program staff from Indiana, Oregon, Iowa, and Wisconsin discussed the difficulties with the subsidy application process for families. For example, a participant from Iowa explained that parents have to come into the welfare office to apply in person during the work day. If they cannot take the time off from work, they cannot apply for a child care subsidy. She explained that transportation to the welfare office is also a barrier for some families, especially in rural parts of Iowa. A participant from Indiana added that going in and applying for a subsidy requires many logistics; parents sometimes need child care just to go to the office and apply. Some families give up part way through the application process because it is so difficult for them. Finally, one participant from Missouri reported that the subsidy application process in her community is demeaning because some caseworkers do not treat parents respectfully.

Subsidy policies and procedures sometimes make it difficult for families to maintain continuity of child care arrangements, a critical component of good-quality care for infants and toddlers. Infants and toddlers who develop a secure attachment with a parent or child care provider are observed to be more mature and more positive in their interactions with adults and peers than are children who lack a secure attachment (Shonkoff and Phillips 2000). However, because of the difficulty many families have in maintaining subsidy eligibility (and thus maintaining stable child care arrangements), children who experience frequent changes in caregivers may end up being more insecurely than securely attached to their child care providers (Shonkoff and Phillips 2000).

Focus group participants from Florida, Missouri, Ohio, California, and New York reported that interruptions in subsidies, and thus child care arrangements, were common. Families lost their subsidy eligibility for a variety of reasons—ranging from job loss to administrative reasons. When parents lose jobs or end participation in work-related activities, many states allow a grace period of 30 days in which to find another job or begin another activity. Some parents, however, are not able to comply with work requirements within this time frame. For example, a participant from Missouri reported that parents in training programs or other educational activities struggle to maintain subsidy eligibility during summer months when they do not have classes. Administrative reasons for losing subsidy eligibility reported by focus group participants included failure to complete paperwork correctly, failure to submit paperwork on time, and difficulties making appointments with caseworkers. Many of the challenges to maintaining subsidies reported by focus group participants also have been documented by studies of child care subsidy use (Adams et al. 2001; and Peck and Meyers 2000).

Lack of Information About Available Child Care Arrangements and Their Quality

Information about child care options and subsidies to pay for them can be difficult for parents to obtain. States face constraints in providing adequate consumer education,

including large caseloads, long waiting lists, and reliance on printed materials (U.S. Department of Health and Human Services 1998). Families who are not linked to the welfare system have less access to information and more practical constraints in learning about child care options than families who are linked to welfare reform (U.S. Department of Health and Human Services 1998).

Although child care resource and referral services are available in many communities, focus group participants reported that low-income families face some challenges in accessing them. For example, focus group participants from Colorado, Washington, and California said that many low-income families do not know that child care resource and referral agencies (CCR&Rs) are available. Unless families are connected with a welfare program, parents are not likely to be aware of the help available through these agencies. In addition, participants reported some variation in the quality of services provided by CCR&Rs. Many said that CCR&Rs in their communities provide excellent services—they monitor availability of slots and provide up-to-date information to families. In other agencies, however, staff turnover has been high and has meant that staff sometimes lack the in-depth knowledge of child care quality for infants and toddlers and community resources required to provide services effectively.

Focus group participants also reported that language barriers can create challenges for some families in accessing information about child care. For example, a focus group participant from California reported that some CCR&Rs do not have bilingual staff available for families who do not speak English. In addition, public service announcements and other educational materials are sometimes offered only in English.

In addition, focus group participants reported that low-income parents often need more information about the quality of child care arrangements. A participant from Kansas said that many parents in her community do not know what good-quality child care looks like or how to select it. Focus group participants noted that while CCR&Rs in their communities provide quality improvement services such as provider training and consumer education, they do not provide parents with information about the quality of specific child care arrangements. Although these agencies do a good job of matching parents with available arrangements and providing guidance about how to identify and select quality arrangements, collecting and reporting quality information about individual providers is not usually part of their mandate.

Lack of Transportation

A lack of transportation also creates barriers for some low-income families in obtaining child care (General Accounting Office 1997). Researchers report that parents who must travel far for care or who do not have a car and cannot find care near a bus line have limited access to care (Pungello and Kurtz-Costes 1999). Because low-income parents live in neighborhoods that are sometimes underserved by public transportation, it is difficult for them to get their children to child care (Larner and Phillips 1994). Moreover, some parents who must use public transportation have expressed concerns about the health of their

infants when they have to wait a long time for buses in the cold (Kirby, Ross, and Puffer 2001).

Focus group participants said lack of transportation was a barrier both for families who live in rural areas and for families who need evening care. In rural areas, often there is no public transportation system that connects to the surrounding rural areas where child care providers may be located. A participant from Missouri reported that her community had evening child care available, but that bus lines closed down in the evening, limiting evening-care options for parents who do not own cars.

As described in this chapter, the barriers that low-income parents face in finding good-quality child care for their infants and toddlers are often daunting. The next chapter provides an overview of the diverse strategies that states and communities have implemented to address these barriers.

CHAPTER IV

OVERVIEW OF INITIATIVES DESIGNED TO INCREASE ACCESS TO GOOD-QUALITY INFANT-TODDLER CHILD CARE

During the past decade, the federal government, states, and communities have initiated a wide range of efforts to expand child care supply and improve the quality of care. Not all of these strategies focus specifically on infant-toddler care, nor do they all focus on the needs of low-income families. Nevertheless, an overview of these efforts provides important context for understanding initiatives that focus on child care for low-income families with infants and toddlers. In this chapter, we draw on recent literature and data from focus groups and telephone interviews to describe five main types of initiatives: (1) activities funded by the Child Care and Development Fund (CCDF), (2) state initiatives to promote local planning, (3) initiatives to increase child care supply, (4) initiatives to improve child care quality, and (5) public-private partnerships to fund child care. While these categories are not mutually exclusive, and some initiatives could be included in more than one category, the overview provides a general understanding of the main types of strategies that have been implemented.

CHILD CARE AND DEVELOPMENT FUND INITIATIVES

PRWORA created CCDF, the primary federal child care funding stream. CCDF unified four previous child care funding streams and increased overall levels of federal funding for child care subsidies.[1] In fiscal year 2001, CCDF made $4.5 billion available to states,

[1]CCDF funds are provided to states in three streams: mandatory, discretionary, and matching. The first two streams do not require matching funds. The mandatory stream is based on funding the state had been receiving from federal child care programs in a base year. Discretionary funds are distributed annually through the congressional appropriations process according to a set formula. The matching stream requires states to maintain their expenditures of state funds for child care programs at specified previous levels and spend additional state funds above those levels (Long et al. 1998; and Greenberg et al. 2000).

territories, and tribes (Child Care Bureau 2001a). Almost all states have allocated matching funds sufficient to draw down their full share of federal funds (American Public Human Services Association 1999; and Blank et al. 2001).

As required by law, most of the CCDF funds are spent on direct child care services. States must spend at least 70 percent of their mandatory and matching funds to meet the child care needs of families who are receiving Temporary Assistance for Needy Families (TANF), are attempting to transition off of TANF, or are at risk for becoming dependent on TANF assistance. In addition, states must spend a substantial portion of funds to provide child care services to low-income working families and must ensure that no more than five percent of the funds expended are used for administrative activities (Greenberg et al. 2000).

CCDF also requires that states spend at least four percent of the funds, including state matching funds, on quality improvement. These funds have supported such activities as training and education for child care providers, salary increases for teachers who completed college courses, consumer education for parents, and child care resource and referral systems. These activities often did not have a special focus on child care for infants and toddlers (Collins et al. 2000). Since 1998, however, CCDF has set aside additional funds for improving the quality of infant-toddler child care. In fiscal year 2001, $100 million was set aside for this purpose. In fiscal year 2001, an additional $172 million was earmarked for quality improvement, in addition to the at-least four percent quality set-aside and the infant-toddler quality set-aside.

Beyond the matching requirements for drawing down CCDF funds, states may also use funds from other sources to provide subsidies to low-income families. States have increasingly used federal and state funds not earmarked for child care, especially TANF block grant funds, to provide subsidies. As welfare caseloads have declined, states have reinvested significant amounts of their unspent TANF funds in child care, either by transferring funds to CCDF or by using TANF funds directly for child care subsidies (Blank et al. 2001). In 2000, a total of $3.9 billion in TANF funds was redirected to child care (Schumacher et al. 2001).

States have flexibility, within broad limits set by CCDF law and regulations, in setting policies for their child care subsidy programs. As a result, state policies vary along many dimensions. The major state policy decisions that broadly affect program eligibility and costs are income eligibility requirements, sliding fee schedules for copayments, and payment rates to providers:

- **Income Eligibility Limits.** While states have latitude in determining eligibility criteria, CCDF regulations limit eligibility for subsidies from CCDF funds to children whose parents (1) are working, (2) are participating in other TANF work activities, or (3) meet some other key criteria (such as being in need of child protective services). States are not allowed to use federal funds to serve families with incomes above 85 percent of the state median income,

and state income eligibility limits range from 37 to 85 percent of median income across states (Child Care Bureau 2001b).

- **Sliding Fee Scales.** Sliding fee scales set the amounts that parents must contribute to the cost of child care (copayments based on their income). Copayments tend to be low or nonexistent for families with incomes below the poverty line. Federal rules allow states to waive copayments for families at or below the federal poverty level. As family income rises above the poverty level, however, many states increase copayments using a sliding fee scale.

- **Provider Reimbursement Rates.** Before PRWORA was enacted, states were required to complete market rate surveys of child care providers every two years and to set payment rates at the 75th percentile—a payment rate high enough to encompass 75 percent of providers or slots in the community (Greenberg 1999). Under PRWORA, this market rate requirement was eliminated. States are not required to pay for child care at the 75th percentile and many states do not. States may set somewhat higher reimbursement rates for certain types of more expensive care that they want to encourage, such as child care at accredited centers or infant-toddler care (Ross 1998).

Despite the recent increases in federal child care funding, CCDF funds are insufficient to serve all eligible families. As a result, most states prioritize families to determine which ones will receive child care assistance. States usually give priority to TANF families, families with very low incomes, children with special needs, and children needing protective services (Adams et al. 2001).

State Initiatives to Promote Local Planning

Several states have developed initiatives to plan and coordinate early childhood services at the local level. These states provide a broad structure and resources to local planning boards, which plan and implement services based on community needs and resources. Here, we describe local planning initiatives in California, Iowa, and North Carolina.

- **California.** In November 1998, the California voters passed Proposition 10, the California Children and Families Act of 1998. Proposition 10 increased the tax on cigarettes and tobacco products by 50 cents to fund state and local programs for early childhood initiatives. Tax revenues (an estimated $680 million for fiscal year 2000) were dedicated to a new California Children and Families Trust Fund to improve early childhood development from the prenatal stage up to age 5. Eighty percent of the sales tax revenue is set aside for county commissions and allocated based on county birth rates. These commissions develop strategic plans for spending the funds after gathering

extensive input from the public on local needs. The remaining 20 percent of the sales tax is reserved for state-level programs and is overseen by the California Children and Families First Commission. Proposition 10 funds may be spent on a wide range of programs to improve the early care and development of children. Some examples are infant-family mental health projects, training for infant-toddler child care providers, expanded training for child care and child development programs in underserved areas, health and family support consultants for child care providers, safety initiatives for child care centers, and incentives to promote accreditation among state-subsidized child care centers. These new funds may not be used to supplant existing levels of funding for early childhood initiatives.

- **Iowa.** The Iowa Community Empowerment Initiative was established in 1998 by the Iowa legislature to create a partnership between communities and state government with the goal of improving the well-being of families with young children. Under this initiative, local community empowerment areas (no smaller than one entire Iowa county or Iowa school district) can form boards made up of community leaders (for example, representatives from schools, the welfare department, the business community, and law enforcement) to assess community needs. Once formed, these boards can apply to the state for community empowerment area status and a share of the state School Ready Grant and federal early childhood funding. These funds are for services to meet the needs of families with young children across the state. The types of activities that have been funded by empowerment area boards vary across communities. They include such activities as voluntary preschool services for children ages birth to 5; voluntary parent education and support services to parents of children ages birth to 5; and planning for services such as child care, child care provider training, and children's health and safety. Focus group participants from Iowa told us that empowerment area boards in their communities had funded incentive programs to promote child care provider training and additional Early Head Start and Head Start slots.

- **North Carolina.** In 1993, the state legislature established Smart Start, an initiative designed to ensure that all children under the age of 6 are healthy and prepared for success when they enter school. To receive a Smart Start grant, each county was required to create a local partnership board with a diverse group of representatives. These boards were responsible for developing a comprehensive service plan to meet the needs of young children in their communities. Smart Start emphasizes three operational themes in its approach: local control, community planning and collaboration, and a comprehensive approach to reach all children. Following are highlights of the accomplishments reported by Smart Start: 155,141 children have received child care subsidies so parents can work; 424,268 children have received higher quality child care; 387,813 children have received preventative health screenings; 246,488 parents have received parenting and

health education; 56,455 new child care slots have been created; more than $125 million in private funds have been raised to support the initiative; and the initiative has been replicated in six states.

Initiatives Designed to Increase Supply

Many states and communities have implemented initiatives to increase the supply of child care. Some of these initiatives focus on increasing the supply of particular types of care, such as infant-toddler care and care during nontraditional work hours. In this section, we describe three main types of strategies that have been implemented to increase child care supply: (1) support for new family child care providers and child care centers, (2) development of new child care facilities, and (3) tiered reimbursement to promote increases in certain types of care (for example, infant-toddler care or care during nonstandard hours).

Support for New Providers

To increase the supply of regulated child care slots, many states and communities offer start-up grants or loans to child care providers. Many states also fund initiatives to recruit and train new child care providers and guide them through the licensing process (Collins et al. 2000).

According to recent literature, several states also have invested funds specifically to establish infant-toddler programs. For example, Washington State earmarked $2.1 million within TANF reinvestment funds for building the supply of infant care. Funds were provided to child care resource and referral agencies as part of an enhancement grant, and community colleges with infant-toddler programs were granted incentives to increase capacity (Blank et al. 2001). Maine targeted $2.6 million from the state's tobacco settlement to increase infant-toddler and preschool care. More than half of the funding provided subsidies to low-income families through the state's voucher program—the remaining portion was put out to bid for contracted child care services (Blank et al. 2001).

Facilities Development

Purchasing and renovating facilities to meet licensing requirements is an expensive task. Public funding is often needed to help providers get started, and a number of states have set aside funds for this purpose. For example, Maryland created a revolving loan fund designed to provide low-cost, short-term loans to help cover the cost of minor renovations in child care facilities and small-group day care homes. The state found the revolving loan fund to be appealing because it did not require a large appropriation, and a greater number of providers could benefit from these loans. California, Illinois, Massachusetts, and Minnesota have also set up revolving loan funds to cover purchases of buildings or land to create new child care facilities or expand existing facilities (Collins et al. 2000). A focus group

participant from California reported that the child care commission in her county used Proposition 10 funds to develop new child care facilities. The commission hired a facilities coordinator to help family and center providers find facilities, build or remodel them, and get licenses. In addition, the board offered grants to providers to help bring their homes and centers up to standards.

Tiered Reimbursement Systems

States may use CCDF funds to set up a system of tiered reimbursement to encourage providers to offer certain types of care. Under these systems, states set higher rate ceilings for specific types of care that are more expensive to provide and that often are in short supply, such as infant-toddler care or evening care. For example, a state may offer higher subsidies for care that is available during nontraditional work hours. Washington, DC, has implemented differential reimbursement rates for such care. The city provides an incentive of 10 percent more for evening care and 15 percent for care provided overnight, on weekends, and during holidays (Blank et al. 2001). Maryland, too, has raised reimbursement rates for providers caring for children during nontraditional hours—on weekdays between 7 P.M. and 6 A.M. or anytime on a weekend. Providers that are providing odd-hour care will be paid a differential between 5 percent and 15 percent above the child's authorized rate (Blank et al. 2000).

Initiatives Designed to Improve Quality

The lack of good-quality child care for infants and toddlers continues to be a critical issue for states and communities. In this section, we provide examples of initiatives designed to improve quality that have been implemented by states and communities. In particular, we discuss provider training and education, technical assistance, support networks for informal providers, support for accreditation, tiered reimbursement, and recognition for providing high-quality care.

Provider Training and Education

Training is one of the most common strategies for enhancing quality among the state and community initiatives we reviewed. For example, the Family Child Care Program at the University of California at Davis (UCD) provides training on quality and safety issues to licensed family child care providers in the state's 58 counties. Participants who complete the training receive a continuing education credit from UCD and a $30 gift certificate for day care learning materials (Collins et al. 2000). Several states are providing additional training opportunities for infant-toddler caregivers in tribal communities: Arkansas, California, Florida, Kansas, Michigan, North Carolina, Ohio, Oklahoma, Vermont, Washington, and Oregon (Fenichel et al. 1999).

A focus group participant from Wisconsin reported that his center received state funds to help infant-toddler teachers obtain credentials and has put together a curriculum for infant-toddler teachers who already working in the field. Once a provider obtains the credential, the employer agrees to give the provider a raise, and the teacher agrees to stay with the center for two years. State funds also provide centers with substitutes while staff are out in training.

The Program for Infant-Toddler Caregivers (PITC), funded by a portion of California's CCDF allocation, is a well-known initiative designed to increase the quality of infant-toddler child care by training caregivers. Created by Western Education (WestEd), in collaboration with the California Department of Education (CDE), PITC is a comprehensive, high-quality, multi-media training system for center-based and family child care providers. The program's goal is to develop a cadre of well-trained, certified graduates in each county who provide training and technical assistance on an ongoing basis to local-level program directors and caregivers. The CDE funds four full-week institutes to train 120 trainers each session to train caregivers to work with children under age 3. California residents are eligible to receive fellowships from the CDE that cover the cost of participation.

Local training and technical assistance is paid for by stipends granted to PITC graduate trainers. The PITC Stipend Training Program (PITCS) was developed to provide ongoing/on-site assistance (60 contact hours) to family child care and center-based infant and toddler care throughout California. PITCS is supported by 11 full-time Regional Trainer/Coordinators stationed around the state to help ensure the quality of local technical assistance and training and to expand local child care initiatives. Any infant-toddler child care program located in California may request PITC technical assistance or training through PITCS. The CCDF provides funds for these initiatives, as well as for the creation of five PITC demonstration sites at community colleges around the state. Other states using the PITC training approach are Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Missouri, Minnesota, North Dakota, South Dakota, South Carolina, and Texas.

Technical Assistance

Some states have implemented technical assistance initiatives to improve the quality of infant-toddler child care. In 1999, Wisconsin Governor Tommy Thompson developed a statewide initiative, the Early Childhood Excellence Initiative, to raise the quality of child care in Wisconsin. A total of $15 million was invested: $1.5 to the University of Wisconsin extension to provide technical assistance and conduct an evaluation of the program; $3.5 million to the Child Care Resource and Referral agencies (CCR&Rs) to reach out to other providers; and $10 million directly to child care centers. Eighteen sites are currently funded, most of which partner and subcontract with other child care providers, parent education specialists, and health consultants. Across all sites, a total of 31 child care centers are participating in the initiative. The goal of this initiative is to take what is being learned at these 31 centers and find ways to spread the knowledge to the other 10,000 licensed child care centers in Wisconsin.

Across the country, many CCR&Rs offer technical assistance to child care providers. For example, the Kansas Association of Child Care Resource and Referral Agencies' Infant-Toddler Project employs 20 infant-toddler specialists statewide to provide technical assistance to infant-toddler child care providers on such topics as infant and toddler development, best practices in group care settings for infants and toddlers, and health and safety issues in infant-toddler settings. The technical assistance is provided during telephone consultation and on-site visits to child care providers. The specialists inform providers that technical assistance is available at training events and when they deliver materials from the Resource and Referral lending library.

Support Networks for Relatives and Friends Who Provide Child Care

Kith and Kin care—informal care provided by relatives or friends—continues to be a very common form of child care for infants and toddlers. Since the passage of TANF and the increasing number of women required to participate in education or work- related activities, the need for child care has emerged as a major public policy issue. There is evidence that families choose relatives and friends deliberately—research shows that parents rely on kith and kin because they want safe care with someone they know and trust (Porter 1998). In addition, there is some evidence that parents' reliance on kith and kin care is due in part to the flexible hours of these arrangements (Porter 1998).

Many communities are working to provide kith and kin providers with support and to improve the quality of care they provide. In Pittsburgh, Pennsylvania, for example, the Neighborhood and Relative Care Project provided training workshops to neighbor and relative caregivers on such topics as child development, working with families and parents, and health and safety issues. The project also offered the caregivers home visits and telephone consultations (Collins and Carlson 1998). The Minnesota Welfare to Work Partnership offered support to kith and kin providers through a network of 23 CCR&Rs. These agencies used a range of approaches to support kith and kin providers, including workshops based on a family support model and help with becoming licensed family child care providers (Collins and Carlson 1998).

Support for Accreditation

States and communities are engaging in a range of activities to encourage child care providers to obtain accreditation. For example, North Carolina has funded incentive programs for child care centers to become accredited (Administration for Children and Families 1999). Nebraska has designated state funds for programs that wish to go through NAEYC accreditation, allowing the fee to be greatly reduced for those programs. In addition, Georgia has tied quality set-aside funds to a commitment on the part of the centers receiving funds to work toward accreditation or to pursue additional training beyond the required training (Blank et al. 2001).

Tiered Reimbursement

Twenty-two states—Arizona, Colorado, Connecticut, Florida, Hawaii, Kentucky, Maine, Minnesota, Missouri, Nebraska, New Jersey, New Mexico, New York, North Carolina, Oklahoma, Oregon, South Carolina, Texas, Utah, Vermont, West Virginia, and Wisconsin—provide higher reimbursement rates for higher quality or accredited care (Schulman et al. 2001). For example, in Colorado, differential rates are offered at the county's option. Some counties opt to pay higher rates to center-based programs that have higher quality, as measured by the Early Childhood Environment Rating Scale (ECERS), a standardized measure of classroom structure, process, and interactions. Counties may also pay higher rates to family child care providers with higher levels of training (Schulman et al. 2001)

Another example is North Carolina's "5 star" licensing system. The higher the center's rating, the higher the rate of reimbursement is for infants and toddlers with subsidies. This encourages providers to actively seek infants and toddlers with subsidies (thereby increasing supply as discussed earlier) and also encourages providers to improve quality. Currently, 57 percent of the children in care in centers are in centers with a 3-to-5-star license.

Recognition for Providing High-Quality Care

Many communities recognize centers that provide high-quality care. In one Nebraska community, for example, there are several different levels of child care program quality enhancement. One is offered through the Health Department at the county level by the Providers Exceeding Licensing Standards (PELS) or the Centers Exceeding Licensing Standards (CELS) program. One set of standards is for home providers, and one is for centers. There is no financial reward associated with PELS or CELS; they are simply ways to provide recognition for quality programs.

Washington's State Training and Registry System (STARS) program promotes and encourages high-quality care by requiring caregivers to complete a minimum level of training before they are able to begin working in centers or in family child care homes. The STARS registry system tracks the training of child care providers and helps providers keep a record of their education and training experience. This registry also provides a resource for families searching for high-quality providers and gives providers the recognition they deserve for additional education and training.

Public-Private Partnerships

A variety of efforts in communities nationwide are financing child care services through public-private partnerships. Several states have created incentives for employers to provide child care assistance. Approaches include loan and grant programs, corporate tax incentives, and information and referral assistance to increase private sector involvement (Nadel 1998). Public-private partnerships in Washington, DC, have increased capacity for infants and toddlers and increased capacity on evenings, weekends, and holidays (Southern Institute on

Children and Families 2000). These partnerships also have resulted in new licensed capacity in child development centers and homes, increased worksite facilities, increased child care subsidies, seminars, expanded roles for child care resource and referral services, and increased training for early care and education providers.

In North Carolina, the T.E.A.C.H. Early Childhood Project provides educational scholarships for child care teachers, center directors, and family child care providers through a combination of private and public dollars. T.E.A.C.H. receives funds from a variety of sources: federal and state governments, corporate and foundation grants, and participants in the program.

The Rochester/Monroe County Early Childhood Development Initiative (ECD) used funds from a variety of sources—federal funds, state and county child care funds, school district funds, city child care funds, private grants, and parent fees—to improve early childhood care and education services in a wide range of settings. For example, the initiative reduced waiting lists, increased reimbursement rates for child care subsidies, offered grants to help centers and homes obtain NAEYC accreditation, offered scholarships to help staff obtain Child Development Associate credentials, and provided start-up funds for new child care facilities (Mitchell et al. 1997).

Conclusion

This chapter has provided an overview of strategies identified through telephone interviews, focus groups, and recent literature that states and communities have used to improve child care quality and expand supply. We found that many of these strategies do not focus specifically on infant-toddler care or care that meets the needs of low-income families. In addition, in some communities, the initiatives did not appear to address comprehensively the barriers families face. Initiatives designed to address one of the barriers low-income families face (such as quality or supply) may be effective and achieve their goals; nevertheless, they may fail to increase low-income families' access to good-quality infant-toddler care because of other barriers families face. For example, quality initiatives may effectively address aspects of quality, such as teacher qualifications or developmentally appropriate equipment. However, because of insufficient supply or the location of providers, low-income families with infants and toddlers may not have access to that care. Similarly, low-income families may have access to state child care subsidies, but they may have difficulty finding good-quality providers who accept subsidies, or they may be unable to maintain their subsidy eligibility due to changes in employment or administrative problems.

Preliminary evidence from the research we have conducted in Year One indicates that one strategy we identified—Early Head Start-Child Care Partnerships—may be better able to address comprehensively the barriers of low-income families with infants and toddlers face. In the following chapters, we will focus on these partnerships in more detail—including the strategies for building partnerships, financing arrangements of the partnerships, community initiatives that can support the partnerships, successes and challenges of the partnerships, and preliminary operational themes gleaned from data collected in Year One.

CHAPTER V

STRATEGIES FOR BUILDING EARLY HEAD START-CHILD CARE PARTNERSHIPS

Since the first Early Head Start programs were funded in 1995 to serve low-income pregnant women and families with infants and toddlers, families' child care needs have increased dramatically. Because of the time limits and work requirements implemented as part of the welfare reforms of 1996, most low-income parents with infants and toddlers must work or participate in work-related activities. In response to families' child care needs, Early Head Start programs have implemented a range of strategies to help low-income families find good-quality infant-toddler child care.

Early Head Start programs and their community child care partners have been in the forefront of efforts to help families arrange good-quality infant-toddler child care. Through our exploration of strategies presented in the previous chapter, we learned that few initiatives focus as intensively as the Early Head Start-child care partnerships on helping low-income families find and pay for good-quality child care for their infants and toddlers. Thus, the next several chapters take an in-depth look at these partnerships.

The experiences of the Early Head Start-child care partnerships provide useful information for policymakers and program operators who seek to implement similar partnership or community collaborative strategies to help low-income families access good-quality infant-toddler care. While the Early Head Start-child care partnerships draw on Early Head Start funds and use the Head Start Program Performance Standards (HSPPS) as their standards for good-quality services, other partnerships that draw on other resources and use other, similar quality standards can benefit from the experiences of Early Head Start-child care partnerships.

In this chapter, we provide a brief overview of Early Head Start and then describe the main types of partnerships we identified, the partnership staffing arrangements, recruitment and selection of child care partners, and partnership agreements and contracts. We also describe the technical assistance and support, teacher training, and materials and equipment offered to child care providers through the partnerships.

Overview of Early Head Start

Early Head Start, which began in 1995, extended Head Start services to low-income pregnant women and families with infants and toddlers up to age 3. A comprehensive, two-generation program, it focuses on enhancing children's development while strengthening families. Today, more than 640 programs across the nation serve more than 55,000 families. Interim findings from the National Early Head Start Evaluation and Research Project indicate that, one year or more after program enrollment, the program had modest positive impacts on 2-year-old Early Head Start children in cognitive, language, and social-emotional development when compared to a control group. In addition, their parents scored higher than control group parents on aspects of the home environment, parenting behavior, and knowledge of infant-toddler development (Administration for Children and Families 2001a).

Early Head Start programs design the services and program options they offer, based on family and community needs. Programs may offer one or more options to families, including (1) a home-based option, in which families receive child development services mainly in weekly home visits and help arranging good-quality child care if they need it; (2) a center-based option, in which children receive early education and care in a center-based setting; (3) a combination option in which families receive a prescribed number of home visits and center-based experiences, and (4) locally designed options, which include family child care in some communities.

Head Start Program Performance Standards

Early Head Start programs must adhere to the revised HSPPS, which took effect in January 1998 (Administration for Children and Families 1996). These standards lay out specific requirements for the quality of Early Head Start services in the areas of early childhood development and health services, family and community partnerships, and program design and management. Through the standards on early childhood development services, the Head Start Bureau has also established a clear set of expectations for the quality of center-based child development services, including child care provided through partnerships with child care providers.[1] For example, the standards require that care be developmentally appropriate and designed to promote the formation of secure relationships by providing continuity of care. Child Care teachers must have a Child Development Associate (CDA) credential or higher degree within a year of hire. Children must be cared for in groups of no more than eight children, with at least one teacher for every four children.

[1]In August 2000, the Administration on Children, Youth and Families issued draft performance standards for services provided through family child care homes (Administration for Children and Families 2000). Under these standards, teachers in family child care homes must have the same qualifications as center-based teachers. Ratio and group size requirements limit groups to six children per teacher when two or fewer children are under age 3. If more than two children are under age 3, the maximum group size is four children, with no more than two children under age 2.

The Head Start Bureau expects Early Head Start programs to take responsibility for helping all families who need to find child care arrangements. Moreover, programs must ensure that these child care arrangements, whether provided in a program-operated child care center or through a community child care provider, adhere to relevant performance standards.

EARLY HEAD START-CHILD CARE PARTNERSHIPS

To meet families' child care needs, many Early Head Start programs have developed partnerships with child care providers in the community that agree to work toward meeting the performance standards. The partnerships, which develop in response to families' child care needs, community characteristics, and available resources, vary from one community to another. They operate under a range of staffing configurations, agreements between programs and child care providers, and financial arrangements. They also vary in the intensity of support and technical assistance child care providers receive from Early Head Start programs. These differences influence the implementation challenges that arise and the successes that partnerships have been able to achieve.

We identified three main types of partnerships: (1) subsidy enhancement partnerships, (2) comprehensive partnerships, and (3) technical assistance partnerships (Table IV.1). These three categories are defined by the types of partnership agreements used, the level of financial support provided, the level of technical assistance and training offered to providers, and the extent to which partnerships can prevent interruptions in child care placements that are due to temporary interruptions in state child care subsidy eligibility. Some Early Head Start programs have developed more than one of these types of partnerships with different child care providers.

Subsidy enhancement partnerships are the most common type of partnership we encountered. Many programs have partnered with community child care providers who agree to collect the state child care subsidy and, in some cases, parent copayments and use supplemental funds from Early Head Start to work toward compliance with the Head Start Program Performance Standards (HSPPS). Child care providers typically use these funds to reduce group sizes and child-staff ratios, enhance their curricula, purchase developmentally appropriate toys and equipment, support teachers in obtaining Child Development Associate (CDA) credentials, and make other changes necessary to comply with the HSPPS.

TABLE V.1

KEY CHARACTERISTICS OF EARLY HEAD START-CHILD CARE PARTNERSHIPS

Partnership Characteristics	Comprehensive Partnerships	Subsidy Enhancement Partnerships	Technical Assistance Partnerships
Partnership Agreements	Formal contract for specific number of slots that meet the HSPPS	Formal contract for specific number of slots that meet the HSPPS	Partnership agreement that specifies steps the provider will take to meet the HSPS. Programs do not contract for specific numbers of slots.
Level of Financial Support	Program pays a per-child rate to cover the full cost of care. Additional costs of meeting the HSPPS are covered, such as extra staff needed to meet ratios, CDA training (cost of courses, compensation for teachers while they attend classes, compensation for substitutes), bonuses for qualified teachers to improve retention, equipment, and renovations.	Program pays a per-child rate to supplement the state child care subsidy and parent copayments collected for each child or an agreed upon portion of staff salaries. Supplemental funds for additional costs of meeting the HSPS are common, such as CDA training, teacher bonuses, and equipment.	Financial support is limited. Per-child supplements to state subsidies and parent copayments are minimal. Purchase of equipment and supplies is limited.
Technical Assistance and Training	Support from Early Head Start is intensive. Usually includes weekly visits to the provider, CDA training, individualized staff development plans, assistance with curriculum development, and financial incentives to encourage compliance with the HSPPS.	Support from Early Head Start is intensive, but usually includes fewer financial incentives.	Regular technical assistance and support is provided, but provision of CDA training, equipment, and supplies is limited.
Safeguards Against Interruptions in Care	Families receive services as long as they are eligible for Early Head Start. Continuity of children's child care placements is not jeopardized by temporary loss of eligibility for state child care subsidies.	To receive services, families must be eligible for Early Head Start services and state child care subsidies. Continuity of children's child care placements is jeopardized by temporary loss of eligibility for state child care subsidies, but partnerships can often maintain the placements in the short term.	To receive services, families must be eligible for Early Head Start services and state child care subsidies. When families lose their child care subsidy and cannot afford to pay for the care, children often lose their child care slots.

SOURCE: Focus groups and individual interviews with Early Head Start staff, child care partners, Head Start and Child Care Bureau staff and technical assistance providers, and others staff from other community programs that support the partnerships.

HSPPS = Head Start Program Performance Standards

CDA = Child Development Associate credential

We classified state-funded Early Head Start programs in Kansas and Missouri as **comprehensive partnerships**. These states provide existing Early Head Start grantees with funding for programs that are identical to the federal Early Head Start program, except that child development services must be provided through community child care providers. These state grants provide the funds necessary to cover the cost of full-day child care that meets the requirements of the HSPPS, as well as funds for Early Head Start staff who support the partnerships. Comprehensive partnerships differ from subsidy enhancement partnerships primarily in that they pay the full cost of the contracted slots, rather than combining enhancement funds from Early Head Start with state child care subsidies. Often, they also provide more intensive support to child care providers than the enhancement partnerships.

Although a number of Early Head Start programs told us that they initially formed **technical assistance partnerships**, most eventually switched to subsidy enhancement partnerships. These programs increased the financial support they offered child care partners in recognition of the additional costs associated with meeting the HSPPS. A few programs we interviewed have developed a set of subsidy enhancement partnerships through which they contract for slots, as well as a set of technical assistance partnerships. These technical assistance partnerships have been developed with a group of providers who care for Early Head Start children (often kith and kin providers or other providers that families have found on their own) but who do not meet the program's quality standards for establishing more formal partnerships and contracting for slots. Some programs have obtained other funding sources, such as state grants, to fund these supportive partnerships.

STAFFING THE PARTNERSHIPS

As Early Head Start programs develop partnerships with child care providers, program staff play a key role in supporting providers' efforts to improve quality and comply with relevant performance standards. These staff are involved in all aspects of the partnerships—from recruiting providers and developing contracts with them to offering technical assistance, support, and training to child care teachers. Almost all programs designate provider liaisons to serve as the primary contact with providers. The provider liaisons are central to the partnerships because they facilitate communication between the partnering organizations and provide a range of services and support to child care providers. Other Early Head Start staff, such as family advocates or disabilities specialists, supplement the support offered to child care partners by the provider liaisons. In addition, some partnerships bring in staff from other community agencies to support child care providers.

Provider Liaisons

Provider liaisons have four main types of responsibilities; some liaisons perform all these tasks, while others perform only a few. First, liaisons participate in the recruitment and selection of child care providers and, after partners are selected, they develop contracts with them. Liaisons interview center staff or family child care providers interested in partnering with Early Head Start, administer quality assessments, review references, and make recommendations about partner selection. Second, they visit partner programs regularly and offer technical assistance in implementing the HSPPS. During visits, liaisons help with curriculum development, observe classrooms and provide feedback, model developmentally appropriate caregiving, review checklists of HSPPS standards, and offer crisis management. Third, liaisons bring equipment, toys, consumable supplies, and other materials to providers. Fourth, they assist child care teachers with professional development, which includes creating individual professional development plans, coordinating training for CDAs, and offering training on pertinent child care topics.

Among the partnerships we studied, the ratio of providers per liaison varied according to the type of partnership and the other duties liaisons performed. Comprehensive

partnerships, which tended to be more generously funded, often employed multiple liaisons who worked full-time on supporting the partnerships. Programs that served fewer children through partnerships or had less funding to support the partnerships usually employed one provider liaison to work with all partnerships. Some liaisons had other responsibilities in addition to their work with providers, such as providing case management services and home visits to families.

The Early Head Start directors we interviewed valued three key attributes of provider liaisons: (1) strong interpersonal skills, (2) relevant education and training, and (3) credibility in the eyes of providers. First, program directors reported that liaisons need to be diplomatic, friendly, and supportive to work effectively with child care partners. Early Head Start programs and child care providers often have different philosophies and organizational cultures. According to directors, liaisons who consider providers as equal partners are able to bridge these organizational differences and work constructively on common goals. Early Head Start directors also value liaisons who have education in a relevant field, preferably early childhood education. Liaisons typically have degrees in early childhood education or social work. Some programs provide additional education in early childhood development to liaisons who need it.

In addition, directors believe that liaisons who have strong credibility in the eyes of providers are able to work more effectively with them. For example, some liaisons had personal experience providing child care. One liaison we interviewed had more than 15 years of experience operating her own family child care home. This past experience helped her gain providers' trust quickly. Other liaisons were known and trusted by providers because they had lived or worked in the providers' communities.

Early Head Start staff also reported some challenges that liaisons faced in their work supporting the partnerships. At some programs, liaisons felt overwhelmed by their responsibilities and did not have enough time to spend with each child care partner. In some cases, liaisons had to reduce the number of visits they made to partners and the intensity of support they offered. At one agency, for example, a liaison was responsible for supporting eight family child care providers and providing case management and other services to the 15 families whose children were placed with those providers.

In addition, Early Head Start directors reported that some liaisons had low morale at times because of high child care teacher turnover or providers' slow progress toward achieving the HSPPS. In some locations, teacher turnover was particularly high because teachers could find higher-paying jobs in other fields. When child care teachers left the partnerships, liaisons had to start over with new staff on working toward meeting the HSPPS and obtaining a CDA credential. In addition, some providers were slow to implement the HSPPS or resisted changing practices that had been in place for many years. Programs also reported that it took time for providers to understand that state licensing requirements are minimum health and safety standards, rather than standards for high quality. Slow progress of some providers toward meeting the HSPPS frustrated some

liaisons, who felt they should have seen larger quality improvements from their heavy investments of time.

Other Staff Supporting the Partnerships

Provider liaisons' work is often supplemented by the work of other Early Head Start staff and by staff from other community agencies. For example, family advocates who provide case management and other services to families may also visit children in their child care settings and share information with providers about children's developmental assessments or family issues affecting child care arrangements. In one instance, an Early Head Start program partnered with a local community action agency that provided two family advocates to work with Early Head Start families.

Some Early Head Start programs also have specialized staff who support the partnerships by offering more in-depth assistance to child care partners on specific issues. At one program, for example, a health specialist visited child care providers every few months to discuss health-related issues, such as immunizations and first aid. Similarly, nutrition specialists provided guidance on nutritional requirements of the HSPPS, and disabilities specialists helped with services for children with special needs.

Program directors reported that collocating staff from different organizations—such as placing Early Head Start staff at child care centers or locating family advocates from other community agencies in the Early Head Start offices—sometimes presented challenges. While some partnerships reported that co-locating staff worked well, such arrangements in other partnerships resulted in confusion over lines of authority and supervision. Some directors reported that having staff members on site who were not under their direct supervision caused confusion. Sometimes staff members were unclear about which tasks they should perform. Likewise, some programs found that supervising staff located off-site at a child care center could be challenging.

Provider Recruitment and Selection

The first step in forming Early Head Start-child care partnerships to address families' child care needs is recruiting and selecting child care partners. As part of this process, programs must decide on the types and numbers of child care partners they want to recruit. The programs we studied made these decisions based on the supply of child care available in the community, parents' needs for locations and hours of care, existing relationships with community child care providers, and the resources available to support the partnerships. This section describes the types of child care partners recruited, as well as common recruitment strategies and selection criteria.

Types of Providers Recruited

In most of the partnerships we studied, Early Head Start programs tried to recruit a mix of child care centers and family child care homes. Many programs reported that they needed both types of providers to meet families' needs for locations and hours of care and to satisfy parents' preferences. Some parents, especially those of infants, preferred a homelike child care setting, while others preferred centers. In addition, some programs we examined operated in multiple counties with different child care options; some counties had mostly child care centers, while others had mostly family child care homes. Comprehensive partnerships were more likely than the others we studied to include a mix of family child care homes and child care centers. Because these programs had substantial resources to support the partnerships, they often had the staff and infrastructure to support multiple partnerships spread across large geographic areas.

A few programs recruited either family child care homes or child care centers exclusively. Programs that recruited only family child care homes did so because of the supply of infant-toddler care available in their communities. One of these programs was in a rural area; another was in an urban setting. However, both reported that few, if any, center-based infant-toddler slots were available in their communities. Another program chose to partner with new home-based providers and help them obtain licenses, because one of its goals was to increase the number of infant-toddler slots available in the community.

A handful of programs partnered only with child care centers. All of these were subsidy enhancement partnerships. Because they had limited resources to invest in partnerships, program staff decided to concentrate their efforts in a small number of partners. In some cases, programs had previously partnered with family child care homes but found that they could not provide the level of support necessary to achieve compliance with the HSPPS. Other programs decided to gain experience in developing partnerships by initially partnering with "in-house" partners, usually child care centers operated by their sponsoring agency but not part of the Early Head Start program. Similarly, a few programs chose to form partnerships with centers that had already formed partnerships with the sponsoring agency to serve Head Start children (4- and 5-year-olds).

None of the Early Head Start programs we studied contracted for slots in license-exempt or kith and kin child care settings. Nevertheless, in several technical assistance partnerships we studied, Early Head Start programs formed partnerships with a range of unlicensed providers who cared for Early Head Start children to work with them on enhancing quality. For example, the state where one partnership is located did not require licensing for family child care providers. Thus, most children were cared for in unlicensed homes. The program formed partnerships with these providers, supported them in obtaining training and meeting health and safety standards, and encouraged them to work toward compliance with the HSPPS. Other programs have reached out to all providers who care for Early Head Start children—whether licensed or unlicensed—to try to form technical assistance partnerships with them.

Recruitment Strategies

Many programs recruited partners by extending an open invitation to all licensed child care providers in their service area. They sent mailings to all licensed providers, asked for recommendations from child care resource and referral agencies and other community organizations, advertised in local newspapers, posted flyers, and made direct in-person or telephone contact with providers. A few programs recruited new family child care providers and helped them to become licensed or sought out newly licensed providers through organizations that provide help with licensing. Many programs reported that they could recruit enough partners using these methods, although a few found recruitment more challenging, especially in rural areas.

Most programs that recruited widely in the community held orientation meetings to describe the partnerships to interested providers and "sell" the benefits of partnering with Early Head Start. During these sessions, staff described the support, technical assistance, and training providers would receive, as well as the standards they would be expected to meet. Comprehensive and subsidy-enhancement partnerships stressed that the level of funding providers will receive per child exceeded funding available through the state child care subsidy program and that providers could also receive help paying for training, equipment, supplies, and minor renovations.

So that as many providers as possible could attend the orientation meetings, they were typically held at multiple times in the evenings and on weekends. If programs covered large geographic service areas, meetings were held in multiple locations. To make the orientation attractive to providers, one Early Head Start program included training on quality caregiving practices in its orientation and arranged for the session to count toward continuing education hours needed to maintain state licensing.

A few Early Head Start programs we studied did not recruit widely in the community. These programs formed subsidy-enhancement partnerships and preferred to concentrate their limited resources on working with a small number of providers. They typically recruited partners based on past experience with the provider in forming Head Start partnerships, recommendations from child care resource and referral agencies, or the provider's reputation in the community.

Selection of Child Care Partners

The Early Head Start programs we studied took three main approaches to selecting child care partners. First, some programs sought the highest-quality child care providers in the community to care for Early Head Start children and screened potential partners using a variety of tools. Often, program staff conducted observational assessments using the Infant-Toddler Environment Rating Scale (ITERS), the Family Day Care Rating Scale (FDCRS), or a screening tool developed by the program. They also reviewed self-assessments completed by providers, assessed their willingness to comply with the HSPPS, conducted reference and background checks, and sometimes assessed providers' philosophies or approaches to

providing services to low-income families. Some programs reported that partnerships were more successful when the partners shared similar philosophies and organizational cultures.

Second, some programs actively worked to expand the supply and improve the quality of infant-toddler care in their communities, while ensuring that Early Head Start children received care that met the requirements of the HSPPS. These programs formed partnerships with providers even if the quality of care they provided was not initially high, as long as they were willing to work toward compliance with the HSPPS and accepted support and technical assistance from the program. In addition to reference and background checks, these programs often used observational assessments, self-assessments, and other quality assessment tools during the recruitment process. However, rather than use the results to screen out potential partners, these programs used them to develop initial quality improvement and staff development plans.

Third, because they did not have enough resources to contract with providers for specific slots, programs that formed technical assistance partnerships often waited until families found child care arrangements, then tried to form partnerships with the providers families selected. In general, programs found this strategy challenging to implement. Often, staff were spread thin across many providers, most of whom cared for only one or two Early Head Start children. Moreover, because programs did not contract with these providers for specific slots and had minimal financial resources to invest in the partnerships, providers sometimes did not see the benefits of the partnership for them and were reluctant (or could not afford) to make the changes necessary to comply with the HSPPS.

Formal Partnership Agreements

Formal partnership agreements are central to the Early Head Start-child care partnerships. They document in writing the expectations of both partners, the resources that each party will bring to the partnership, and the activities that each party agrees to carry out through the partnership. Often, these documents represent the culmination of an in-depth decision-making process about whether to go forward with the partnership and a negotiation phase in which the specific terms of the partnership are decided.

Partnership agreements vary in formality and level of detail. Some programs develop formal contracts with child care providers in which they contract for specific slots and describe in detail the payment terms for those slots and each partner's responsibilities for ensuring compliance with elements of the HSPPS. Other agreements are less detailed. This section describes the content of typical Early Head Start-child care partnership agreements, including resources that Early Head Start programs provide and the quality standards that providers agree to meet.

Resources

The financial aspects of the partnership agreements we studied varied according to the type of partnership formed. In general, comprehensive partnerships developed the most detailed contracts. They usually specified the rate Early Head Start programs would pay for each slot, the payments programs would provide for other expenses like CDA training, and, when offered, the incentive payments available to providers that achieved certain benchmarks. Many agreements for subsidy-enhancement contracts were similar, except that the provider usually agreed to collect the state child care subsidy and, sometimes, a parent copayment for each child. Agreements for technical assistance contracts often included fewer financial arrangements. Specific payments per child were minimal. Financial rewards for providers—such as minimal per-child payments, purchase of supplies or equipment, or payment for teachers to attend training—usually were provided as an incentive for taking steps toward meeting the HSPPS, rather than as compensation for care provided to specific children. Here, we describe the range of financial agreements negotiated by the partnerships we studied:

- **Rate per Child to Cover the Full Cost of Care.** Comprehensive partnerships paid an agreed-upon rate—hourly, daily, weekly, or monthly—for the full cost of care. Thus, providers did not have to collect state child care subsidy funds or parent copayments. Programs reported that, in recognition of the resources needed to comply with the HSPPS, the rates they negotiated with providers were higher than state subsidy rates. Many comprehensive programs also paid for days when children were absent (states typically limit the number of absences they pay for), and some paid to hold vacant slots for a specified period of time.

- **Supplemental Rate per Child.** Subsidy-enhancement partnerships typically paid a monthly or weekly rate to supplement the funds providers collected from the state child care subsidy program and, in some cases, from parents. For example, one program supplemented the state subsidy rate, which was 75 percent of the market rate, to bring the provider's income per Early Head Start child up to approximately 125 percent of the market rate. As with comprehensive partnerships, subsidy enhancement partnerships often covered the cost of absences. Almost all the program directors we interviewed told us that these funds were intended to enhance the quality of care throughout the day (sometimes called a "wrap-in" approach), rather than fund an Early Head Start portion of the day. These programs avoided arrangements in which subsidized child care "wraps around" a specified number of Early Head Start hours, because they wanted all of the care children receive to meet the HSPPS.

- **Payments for CDA Training.** Almost all programs we examined paid for the cost of CDA training for child care teachers or provided the training directly to teachers at no cost. In addition, many comprehensive and some

subsidy enhancement partnerships paid for substitutes while teachers attended training, compensated teachers for the hours they spent in training on evenings and weekends, and paid for transportation to training.

- **Funding for Additional Staff.** In a few of the subsidy-enhancement partnerships we studied, Early Head Start programs paid the salaries of additional child care teachers needed to reduce ratios and group sizes in compliance with the HSPPS. These programs recognized that their child care partners could not afford to remain in the partnerships unless they had funds to hire additional staff.

- **Salary Enhancements.** To address staff turnover problems, one subsidy-enhancement partnership negotiated a supplement to the hourly rate of child care teachers, assistant teachers, and directors. Other programs negotiated one-time bonuses or monthly bonuses for staff who obtained CDA credentials or an Associate's degree.

- **Incentive Payments.** Several of the comprehensive partnerships we examined built incentive payments for achieving specific quality goals into their agreements. For example, some programs paid bonuses to providers for sustaining the partnerships for specified intervals, for making progress toward meeting the HSPPS, for teachers who obtained CDAs, and for maintaining ratios of no more than four children per teacher. One technical assistance partnership rewarded providers with small perks such as consumable supplies, payment of training fees, membership in professional organizations, and access to a computer in exchange for achieving specific steps toward compliance with the HSPPS. Some of these included maintenance of Cardiopulmonary Resuscitation (CPR) certification, participation in first-aid training, completing at least 10 hours of annual training, participating in training on the HSPPS, and participating in the Child and Adult Care Food Program.

- **Tiered Payment Systems.** Some partnerships incorporated tiered payment systems into their agreements. Child care partners who achieved specific quality benchmarks became eligible for higher per-child rates. For example, one program provided child care partners with a higher per-child payment once teachers obtained CDA credentials.

- **Payments for Equipment, Supplies, and Renovations.** Almost all partnerships provided some toys and equipment to providers, either by purchasing the items or loaning them through a lending library. Many comprehensive and subsidy enhancement partnerships supplied providers with large amounts of equipment and toys. Some also helped providers pay for minor renovations to make facilities accessible to children with special needs, to reduce group sizes, or to improve outside play areas.

Standards

The main goal of the Early Head Start-child care partnerships is to ensure that the combination of services provided by the program and the child care provider meets the requirements of the HSPPS. Thus, most partnership agreements focus heavily on the HSPPS and how the partnership will achieve compliance with the agreements. Almost all agreements state that providers must meet or work toward meeting relevant standards, and many outline the specific standards the child care partners must meet. In addition, they describe all the supports and services the Early Head Start program will provide to the child care partner to help achieve compliance with the standards. Some also list the standards for which the program will take primary responsibility.

Most of the Early Head Start programs we examined required child care partners to comply with the HSPPS in all of their classrooms and with all infants and toddlers in their care. For example, partnership agreements required child care partners to maintain child-teacher ratios of 4-to-1 and group sizes of no more than eight children in all infant-toddler classrooms (or in family child care providers' homes). Programs supported all infant-toddler teachers in obtaining a CDA credential, whether or not they cared for an Early Head Start child. Similarly, teachers implemented developmentally appropriate curricula with all children in their care.

In contrast, a few programs we studied reported that they required partners to implement the HSPPS only in certain classrooms designated for Early Head Start children. One program director said that, in the past, it was overwhelming for partners to require all teachers to obtain CDAs and implement a new curriculum. Program staff decided that working with a smaller number of staff in specific rooms might be more manageable for partners and yield more substantial improvements in quality in those rooms.

While the programmatic aspects of the partnership agreements vary across the partnerships we studied, the following are services and standards that partnership agreements typically covered:

- **Health and Safety Standards.** Partnership agreements typically required providers to maintain their licenses and to meet basic standards for health and safety, such as child-proofing family child care homes and implementing sanitary diaper-changing procedures. Some partnership agreements also required first aid and CPR training.
- **Child-Teacher Ratios and Group Sizes.** Most partnership agreements required that child care providers comply with the HSPPS standards of no more than four children per teacher and eight children per group.
- **Teacher Qualifications.** Most partnership agreements required child care teachers to obtain their CDA credential within a year of initiating the partnership or within a year of hire.

- **Child Development Services.** Although partnerships used a variety of curricula, the most frequently used curriculum among partnerships we studied was the *Creative Curriculum for Infants and Toddlers* (Dombro et al. 1997). With support from program staff, some child care teachers participated in assessments of children's development, often using the *Ages & Stages Questionnaires* (Bricker and Squires 1999).[2] In addition, Early Head Start liaisons worked with child care teachers on individualizing activities to meet the needs of each child. Many programs required teachers to implement systems for regular observation of children and documentation of their developmental progress. In one partnership, for example, family child care providers assembled portfolios to chart children's progress. The portfolios included developmental assessments, observation notes, and sometimes even video- and audiotapes of the children.

- **Communication with Parents.** Partnership agreements frequently included requirements for communication with parents. For example, some programs asked child care providers to develop parent handbooks, post policies in their classrooms or homes, and conduct at least two parent-teacher conferences and at least two home visits per year.

- **Nutrition Services.** In some partnerships, child care providers were responsible for some Early Head Start nutrition services, such as meeting standards for provision of meals, including requirements for serving food family style. In some partnerships, programs provided the services of nutritionists to consult with providers on menu planning.

Technical Assistance and Support

Across all the partnerships we examined, Early Head Start programs provided substantial technical assistance and support to their child care partners. Most of this support was provided by provider liaisons who visited the providers regularly. These visits ranged from one hour per week per Early Head Start child to monthly visits, with most provider liaisons visiting weekly or biweekly. During these visits, provider liaisons assessed quality and adherence to the HSPPS, worked on goal plans with providers, provided on-site technical assistance and hands-on training, and worked with providers on curriculum and lesson planning. As needed, liaisons brought in other program or outside experts to support the child care partners.

[2]In other programs, Early Head Start family advocates or other staff worked with parents in their homes to conduct developmental assessments, then shared the results with child care teachers.

Technical Assistance Offered by Provider Liaisons

Liaisons assessed the quality of child care that partners provided, usually when the partnership began and at regular intervals throughout the partnership. Many programs used the ITERS in centers or the FDCRS in family child care homes to assess quality. Some reviewed checklists based on the HSPPS with partners at regular intervals, and others asked partners to complete self-assessments. A few programs worked with their child care partners to implement management information systems that helped them track the services partners provided.

In most partnerships, provider liaisons used the results of these assessments to identify technical assistance needs. For example, one partnership used the results of the ITERS to develop an environmental goal plan, which included specific changes the provider would make and equipment and training that the program would provide. Other partnerships used the assessment results to develop goal plans for meeting the HSPPS. Liaisons and providers identified the standards they would focus on, identified specific steps needed to meet these standards, and designated which partner (program or provider) would complete each of the steps.

Early Head Start programs reported that liaisons spent most of their on-site time with providers giving hands-on technical assistance. Liaisons spent a substantial amount of time modeling developmentally appropriate behavior and coaching child care teachers. They helped teachers implement their curricula and helped them develop lesson plans for their classrooms and individualized plans for each child. In addition, liaisons shared information from children's developmental assessments (when the assessments were done in families' homes by other Early Head Start staff) and other information on children's health or families' circumstances that could affect child care.

Family child care providers reported that liaisons sometimes helped them with the business aspects of running their family child care homes, and they helped with crisis management. For example, one provider cared for a child who was the subject of a custody case involving allegations of abuse. During this time, the liaison kept in touch with the provider daily, helped her prepare documentation on the situation, and brought her a cordless telephone so that she could call from anywhere in her house.

Finally, several programs held regular meetings, usually once or twice a month, with all of their child care partners. During these meetings, participants discussed enrollment, policies and procedures, upcoming training opportunities, and other issues. In addition, the child care providers had an opportunity to interact and discuss common issues.

Early Head Start staff and their child care partners also told us about some challenging aspects of technical assistance. In several partnerships, differences between the HSPPS and state licensing requirements created difficulties. Some providers were confused about why there were differences and which set of standards they should follow. Moreover, some child care providers were reluctant to reduce their ratios and group sizes below those the state required, in part because of the cost of these changes. In some partnerships, figuring out

how to implement the portions of the HSPPS developed for center-based care in family child care settings was also challenging.

Technical Assistance for Early Head Start Staff

In some partnerships, Early Head Start staff received ongoing technical assistance on partnering with child care providers. For example, in Kansas and Missouri, state agencies convened monthly meetings for their state-funded Early Head Start grantees. The meetings included state agency staff, Early Head Start staff, and staff from the Administration for Children and Families' regional office. Programs appreciated these meetings, because they provided a regular opportunity to talk with the state about the partnerships and to share ideas among themselves. The City of Chicago, which contracts with delegate agencies to provide Early Head Start services through partnerships with family child care providers, maintains a support services unit to provide technical assistance to delegate agency staff who operate the partnerships. In addition, the City of Chicago has partnered with The Erikson Institute to provide an in-depth training program for provider liaisons who need additional education in early childhood development.

Training for Child Care Teachers

According to the HSPPS, child care teachers must have a CDA credential or a higher degree within one year after they are hired. To meet this requirement, virtually all of the Early Head Start programs we examined helped their partners' child care teachers obtain CDA credentials. In addition, Early Head Start programs helped child care teachers access a variety of other training. In typical partnerships, provider liaisons worked with each child care teacher to develop an individual staff development plan that identified her training needs and described plans for meeting those needs. Early Head Start programs helped child care teachers access CDA classes and other training by providing it directly or by helping teachers enroll in courses offered by local community colleges and other community agencies, such as child care resource and referral agencies.

Early Head Start programs used a variety of strategies to tailor training to the needs of child care providers. Some programs paid for substitutes while teachers attended training. Many arranged for classes to be offered during evenings and on weekends. A few programs partnered with community colleges that could provide CDA training in Spanish. In addition, for family child care providers in rural areas, some programs implemented independent-study CDA programs. Provider liaisons supplied materials, provided some instruction, and served as substitutes while family child care teachers took tests.

Help with Materials, Equipment, and Renovations

Most Early Head Start programs we examined provided their child care partners with developmentally appropriate toys and equipment. Some provided consumable supplies

(such as plastic gloves for changing diapers), shelving, and minor renovations. Many programs purchased materials and equipment for providers based on an initial assessment of their needs, then supplied additional items as incentives for continuing progress in meeting the HSPPS. Typically, although these items were given to providers, they remained part of the Early Head Start inventory and had to be returned when the partnership ended. Some programs, however, allowed providers to keep a portion of the items after specified time periods as an incentive to continue the partnerships. Other programs, especially those that formed technical assistance partnerships, lent toys and equipment to providers on a rotating basis.

Several of the partnerships we examined also helped with minor renovations needed to comply with the HSPPS. For example, one program provided a child care partner with partitions for dividing infant-toddler rooms to comply with group size requirements. Other programs helped pay for construction of ramps to make providers' homes or centers more accessible. They have also paid for modifications to decks, playgrounds, and other outside spaces to make them safe for infants and toddlers.

CHAPTER VI

PARTNERING WITH COMMUNITY INITIATIVES

As described in Chapter IV, the federal government, states, and communities have implemented a range of initiatives and strategies aimed at increasing the supply or quality of child care. These initiatives may provide additional opportunities for collaboration or opportunities to combine resources to work toward common goals. Most of the Early Head Start-child care partnerships we examined were drawing on at least one of these initiatives for additional resources to support their partnerships. Other initiatives and partnerships with similar goals may also benefit from working with or participating in these initiatives.

Many of the Early Head Start programs had developed formal partnerships with other agencies that could contribute to the child care partnerships by providing training or specialized services. Collaboration with other initiatives was more informal. This chapter describes the main types of other agencies and initiatives that the partnerships drew on to support their work.

COLLABORATION WITH CHILD CARE RESOURCE AND REFERRAL AGENCIES

Many of the partnerships we examined collaborated extensively with child care resource and referral agencies (CCR&Rs) located in their communities. Early Head Start programs that maintained partnerships with child care providers in multiple counties often collaborated with several CCR&Rs, and some programs even had CCR&R staff co-located in their offices. The partnerships reported receiving help from CCR&Rs in three main areas: (1) provider training and technical assistance, (2) provider recruitment, and (3) resource and referral services for families.

Early Head Start programs often collaborated with CCR&Rs to provide training and support to child care partners. For example, in one partnership the CCR&R provided CDA training for child care teachers. In another, CCR&R staff served as CDA advisors for family

child care providers. Some Early Head Start programs offered training workshops for child care partners and other community child care providers jointly with CCR&Rs. A few had formal contracts with CCR&Rs to provide child care training. One program contracted with a CCR&R to supply training, technical assistance, and other provider liaison services for its child care partners.

A number of Early Head Start programs relied on CCR&Rs for recommendations of potential child care partners, either initially when they began forming child care partnerships or on an ongoing basis. One program contracted with a CCR&R to help Early Head Start families find child care providers who met the program's quality standards and then develop formal subsidy enhancement partnership contracts with them. Other Early Head Start programs, usually those that served at least some families through the home-based option, reported that they relied on CCR&Rs to help families find child care when available partnership slots did not meet families' child care needs in terms of hours, location, or parent preferences.

Although most Early Head Start programs valued their partnerships with CCR&Rs, programs also described some challenges to collaborating with CCR&Rs. In some communities, Early Head Start programs wanted to collaborate with the local CCR&R to provide training or recruit child care partners but could not, because the CCR&R charged high fees for these services. Other programs reported that some of the CCR&Rs operating in their service areas did not provide training or referral services of good quality, usually because staff did not have adequate knowledge of early childhood development. Finally, a few programs reported that differences in organizational culture and quality standards (usually differences between the HSPPS and state licensing requirements) sometimes made collaborating with CCR&Rs challenging.

PROFESSIONAL DEVELOPMENT

Early Head Start programs developed partnerships with a range of organizations and initiatives to support the professional development of child care teachers. In addition to collaborating with CCR&Rs, many programs collaborated with community colleges to support child care teachers in obtaining CDA credentials. Programs worked closely with community colleges to design curricula, enroll child care teachers, and support teachers while they attended classes. In addition, child care teachers in some of the partnerships received scholarships for CDA training and compensation bonuses through state-sponsored Teacher Education and Compensation Helps (TEACH) initiatives.[1] Several programs supported child care teachers' participation in WestEd's Program for Infant and Toddler Caregivers

[1]TEACH provides child care teachers with educational scholarships, increased compensation following completion of education programs, and agreements to continue working in child care for a specified period of time after completion of the education program. TEACH was developed and first implemented in North Carolina in 1990; since then, it has been implemented in more than 15 states (Child Care Services Association 2001).

(PITC).[2] Finally, one program reported using funds from a U.S. Department of Labor apprenticeship program to support child care teachers' professional development through CDA training, salary enhancement, and oversight by a journeyperson assigned to each apprentice.

A few of the Early Head Start programs we studied also established initiatives to support the professional development of provider liaisons. For example, the Chicago Department of Human Services partnered with the Erikson Institute to offer provider liaisons intensive training in infant development. Through this partnership, Erikson provided a two-year Infant Studies Program designed especially for the provider liaisons and consisting of four graduate-level courses (Infant Growth and Development, Family Studies, Methods, and Infant Assessment), a seminar, and an internship. Liaisons had access to volunteer tutors through the Erikson Institute who helped them with academic writing. At the end of the program, provider liaisons received an infant studies certificate with a specialization in child care.

IDENTIFYING POTENTIAL CHILD CARE PARTNERS

In addition to CCR&Rs, some Early Head Start programs collaborated with other community agencies or initiatives to identify potential child care partners. For example, staff from an Early Head Start program in Delaware accompanied staff from Families and Children First, a community agency, on an outreach van to visit family child care providers in the community. Through these outreach activities, Early Head Start staff were able to identify potential partners, offer them free training, and talk with them one-on-one about forming partnerships. The Chicago Department of Human Services collaborated with the Westside Consortium, a local community organization, to recruit family child care providers. This organization offered training and help with state licensing to unregulated child care providers. Once the providers obtained their licenses, the Westside Consortium referred them to the Chicago Department of Human Services, which linked them with a delegate agency in their area.

In Nebraska, some Early Head Start programs used the state-funded Infant-Toddler Initiative to identify potential partners. Programs used funds from this initiative to support partnerships with child care providers who cared for Early Head Start children but did not meet the program's quality standards for establishing more formal partnerships with contracted slots. Programs reported, however, that these providers could become eligible to enter into more formal subsidy enhancement partnerships with the programs, once their quality improved.

[2]PITC is a comprehensive training program for center-based caregivers and family child care providers developed by WestEd's Center for Child and Family Studies in collaboration with the California Department of Education's Child Development Division (WestEd 2001).

Initiatives to Support Healthy Child Care Environments

Several programs drew on community resources to support their child care partners in maintaining healthy child care environments. For example, an Early Head Start program in Lincoln, Nebraska, used resources available through the University of Nebraska to provide health-related support to child care partners. A registered dietician from the Lincoln Cooperative Extension provided training on nutrition and menu planning to child care partners and reviewed their menus. Staff from the university's Psychological Consultation Center observed children's behavior in child care and served as mental health consultants for child care partners. In Nebraska, some programs also drew on local health department staff to provide training to child care partners on serving children with special needs.

In addition, some partnerships we examined collaborated with community initiatives funded by Healthy Child Care America. In one Iowa partnership, the Early Head Start program and a Healthy Child Care Iowa (HCCI) nurse were co-located and worked closely to support the program's child care partners.[3] The nurse conducted a health and safety check for each provider, and then HCCI or the Early Head Start program provided any needed safety supplies or equipment. The nurse also conducted playground safety checks and worked with some providers on improving playground safety.

[3]Healthy Child Care America is an initiative to promote safe, healthy child care environments for all children. It is sponsored by the Child Care Bureau and the Maternal and Child Health Bureau of the U.S. Department of Health and Human Services, which contracts with the American Academy of Pediatrics to coordinate the initiative. In addition, the Maternal and Child Health Bureau funds states to implement community projects aimed at service integration and health systems development in child care (NCCIC 2001).

CHAPTER VII

FINANCING THE PARTNERSHIPS

State child care subsidies often are not sufficient to provide child care that meets the quality standards contained in the HSPPS or other professional standards. Similarly, Early Head Start grants usually do not provide enough funding per family to provide full-day, full-year child care that meets the HSPPS and the comprehensive child and family services that the standards require. Thus, Early Head Start-child care partnerships must draw on multiple funding sources to meet families' child care needs and comply with the HSPPS. Through a series of communications and information memoranda to states and Early Head Start grantees, the Administration for Children and Families has encouraged the blending of funding sources to address the child care needs of children and families and improve the quality of services provided (Administration for Children and Families 1999b; Administration for Children and Families 2001a; and Administration for Children and Families 2001b).

This chapter describes the types of blended funding arrangements that the Early Head Start-child care partnerships we studied used to pay for child care. Because good-quality infant-toddler child care is so expensive to provide, other programs and collaborative initiatives designed to help low-income families access good-quality care would likely need to blend funding from multiple sources to pay for care. Thus, the experiences of the partnerships we studied may provide useful lessons for similar partnerships or initiatives.

COMBINING EARLY HEAD START FUNDS AND STATE CHILD CARE SUBSIDIES

Most of the Early Head Start-child care partnerships we examined drew on state child care subsidy funds and the Early Head Start grant to pay for child care. This is the funding arrangement employed by subsidy enhancement partnerships, as described in Chapter IV. Under this arrangement, community child care providers agree to collect the state child care subsidy payment and, in some cases, copayments from parents. In recognition of the additional costs associated with adhering to the HSPPS, Early Head Start programs agree to provide funds to supplement the state child care subsidy.

The Early Head Start programs that we talked to used a range of strategies for supplementing the income that providers received from state child care subsidies. Some programs paid providers a regular enhancement rate, usually weekly or monthly. Others paid a regular rate and also provided funds for CDA training, supplies and equipment, and staff bonuses. A few programs paid a portion of partners' child care teacher salaries to compensate providers for reducing teacher-child ratios and group sizes. In addition, while many states limit the number of child absences they will pay for, many of the partnerships provided the subsidy enhancement funds even when children were absent. Some also paid to hold vacant slots open for a specified period of time, until Early Head Start children could be placed in those slots.

Challenges Faced by Partnerships that Combine Early Head Start and State Subsidy Funds

Although combining Early Head Start funds and state child care subsidies has worked well for many children and families served through the partnerships we examined, many of the partnerships identified challenges for some families associated with this financing arrangement. One significant challenge was the difference in the eligibility periods of Early Head Start and state child care subsidy programs. While children enrolled in Early Head Start maintain their eligibility for a year or more, the eligibility period for state child care subsidies is usually much less than one year. Consequently, children can lose their eligibility for the state child care subsidy—and, thus, a major source of their child care funding—well before their eligibility for Early Head Start ends.

Children lose their eligibility for the state child care subsidy, for a variety of reasons. To maintain eligibility for the subsidy, parents must work or participate in a work-related activity. Thus, children can lose eligibility when their parents quit or lose jobs. Although many states allow parents a grace period of 30 days in which to find another job and begin working, some parents are not able to go back to work within this time frame. For example, one program reported that a parent lost her subsidy after a car accident which left her unable to work while she recovered from injuries. Others lose eligibility when parents are between work activities, such as during the winter break at a community college. Still others lose eligibility for administrative reasons. For example, some parents have trouble making redetermination appointments, especially when offices are open only during traditional working hours. Some parents do not complete forms correctly, do not report changes in status, or do not return forms to a caseworker on time. Many of the challenges to maintaining child care subsidy eligibility reported by the Early Head Start-child care partnerships have been reported by other studies of state child care subsidy use (Adams et al. 2001; and Peck and Meyers 2000).

Regardless of the reasons, loss of child care subsidy eligibility poses a major challenge for the Early Head Start-child care partnerships. The HSPPS require programs to ensure stability in care arrangements so that continuity of care for children can be maintained. Stable child care arrangements in which children can form strong attachments with a limited

number of caregivers contribute to more positive child outcomes (NICHD Early Child Care Research Network 1996). However, unless the partnerships have alternative sources of funding with which to pay for costs previously covered by state child care subsidy funds, children who lose subsidy eligibility usually lose their child care arrangements.

Some of the Early Head Start-child care partnerships we studied had alternative funding sources to cover child care costs during short-term interruptions in subsidy payments. For example, the Puget Sound Education Service District in Washington State maintained an emergency fund to cover child care costs during interruptions in subsidy payments that lasted for up to three months. A partnership in Nebraska relied on a child care provider to help cover these costs using private funding sources. Some partnerships tried to help parents cover the costs by setting up reduced-fee schedules or establishing payment plans that gave parents more time to pay for days not covered by the subsidy. Finally, some programs told us that when families lost their subsidy, the program offered to continue providing Early Head Start services through the home-based option, but could not the maintain the child care placement.

Some of the partnerships we studied also reported a second challenge associated with combining Early Head Start and state child care subsidy funds. In some states, partnerships reported that child care providers frequently experienced long delays in receiving subsidy payments from the state. When states were slow to pay providers, some—especially family child care providers—experienced cash flow problems and faced difficulties in maintaining their businesses. Moreover, such problems with subsidy payments made providers reluctant to accept subsidized children and maintain their partnerships with Early Head Start programs.

A few of the partnerships we studied developed strategies for addressing problems associated with state subsidy payments that are slow to arrive. For example, an Early Head Start program in Colorado reported that the state pays child care providers about four to six weeks after services are delivered. This schedule can result in severe cash-flow problems for family child care providers. Through Colorado's Consolidated Child Care Pilot Project, the program was able to obtain a waiver from the state which allows a nonprofit child care program to act as the fiscal agent for a network of family child care homes. The fiscal agent paid providers weekly to ensure consistent cash flow and then collected the subsidy payments from the state on behalf of these providers.

Other State Funding Sources

Early Head Start-child care partners in several states blend Early Head Start funds and state funding sources other than child care subsidies to pay for child care. An advantage of these alternative funding sources is that children and families are not subject to the state's child care subsidy eligibility period. Programs can serve families according to Early Head Start eligibility requirements without the risk of losing part of their child care funding midway through the program. The rest of this section provides examples of state funding sources from Kansas, Missouri, Nebraska, and Iowa.

State-Funded Early Head Start Programs in Kansas and Missouri

The states of Kansas and Missouri have funded programs that are identical to federally funded Early Head Start (they must also conform to the federal HSPPS), except that programs must provide child development services through partnerships with community child care providers. This is the funding arrangement employed by the comprehensive partnerships described in Chapter IV. The Kansas initiative, which has been operating for more than three years, funds 13 programs using transfers from TANF funds. Thus far, the program has served about 2,000 children. Similarly, Missouri funds 11 programs using a combination of state revenues from taxes on gambling and transfers from TANF funds. This program has been operating for about two years and has served approximately 850 children. Because the programs are not subject to the eligibility requirements of the state child care subsidy program, maintaining continuity of care for enrolled children is not a significant challenge.

Nebraska's Infant/Toddler Initiative

Nebraska has dedicated a portion of its infant-toddler quality enhancement funds from CCDF to support Early Head Start-child care partnerships. The state made grants to Early Head Start programs to form new partnerships with child care providers beyond those partnerships funded by the federal grant. One Nebraska program used the funds to develop technical assistance partnerships with providers who were caring for Early Head Start children enrolled in the home-based option. Usually, these were providers that families have found on their own. A provider liaison visited the providers regularly to provide technical assistance, provide some materials and supplies, and encourage child care teachers to attend training. The program, however, did not contract with these providers for slots or provide subsidy-enhancement funds.

Iowa's Community Empowerment Initiative

Through local planning boards, Iowa's Community Empowerment Initiatives provides grants for services to meet the needs of families with young children. The types of activities funded vary across the boards and communities. Many of the planning boards are funding child care initiatives in their communities. In addition, some of the boards are providing grants to fund additional Early Head Start and Head Start slots. Grants from these boards can be an additional source of funding for the Early Head Start-child care partnerships.

PRIVATE FUNDING SOURCES

We found only limited use of private funding sources among the Early Head Start-child care partnerships we examined. Some partnerships used private funds to pay for one component of their partnerships, but none of the partnerships relied on private funds as a significant portion of their funding. For example, in Chicago, the Infant Studies Program for provider liaisons coordinated by the Erikson Institute (see Chapter VI) is funded in part by foundation grants. In Nebraska, one program partnered with a large nonprofit agency that provided child care and other services to low-income families. Because the agency had a variety of private-funding sources, it could occasionally draw on private funds to cover the child care costs for a family that has lost its eligibility for the state child care subsidy. Finally, in some partnerships, community colleges or schools donated space to the partnerships.

CHAPTER VIII

EMERGING THEMES: PARTNERSHIP SUCCESSES AND CHALLENGES

The experiences of Early Head Start programs and child care providers in developing and sustaining their partnerships can provide valuable insights for others who seek to implement similar collaborative community strategies to help low-income families with infants and toddlers find and pay for good-quality child care. As communities and other service providers seek ways to help low-income families with young children meet their child care needs, many are considering the possibility of forming partnerships and other local collaborative initiatives. Moreover, as states work to expand the supply and improve the quality of infant-toddler care, they often include Early Head Start programs and their community partners in the planning and implementation stages of their efforts.

In this chapter, we provide a preliminary report on the main successes identified by the Early Head Start-child care partnerships we studied in Year One and the key challenges they have faced. While not achieved in all the partnerships we talked to, the successes identified in this chapter illustrate the potential of partnerships to improve low-income families' access to good-quality infant-toddler care. Likewise, the experiences of the partnerships included in this study indicate the types of challenges similar initiatives in other communities may face.

EMERGING THEMES: PARTNERSHIP SUCCESSES

Developing an Early Head Start-child care partnership is a complex task. It requires planning carefully, communicating clearly, mobilizing community resources, and meshing different organizational cultures and practices. Many of the partnerships included in Year One of the study have navigated these complexities and achieved important successes in meeting families' needs for good-quality infant-toddler child care. The partnerships have made improvements in the key structural features of child care settings thought to influence quality. Many child care partners reported significant progress toward achieving compliance with the HSPPS. In some communities, partnerships have increased the number of infant-

toddler child care slots available; in others, collaboration among service providers has increased. The rest of this section describes each of these successes in more detail.

Improving Quality and HSPPS Compliance

Through resources provided by the partnerships we examined, child care providers were able to improve structural aspects of child care settings which, research has shown, are closely associated with quality and which achieve compliance with key components of the HSPPS.

Reducing Child-Teacher Ratios and Group Sizes. In many comprehensive and subsidy enhancement partnerships, child care providers were able to reduce ratios and group sizes to those required by the HSPPS (four children per teacher and eight children per group). Early Head Start programs supported these reductions by paying the salaries of additional teachers and paying the cost of structural changes, such as the installation of partitions.

Enhancing Professional Development of Child Care Teachers. Most child care teachers in the partnerships we examined who lacked a CDA credential were able to obtain one within a year. In some partnerships, teachers took additional classes; some obtained associate's degrees. Almost all the partnerships helped teachers participate in other training, such as the Program for Infant and Toddler Caregivers (PITC). In addition, some child care partners attended professional conferences. Others became active in professional organizations and provider networks.

Implementing More Developmentally Appropriate Practices. Many of the Early Head Start programs we contacted reported that, as child care teachers participated in CDA training and received technical assistance from provider liaisons, they began to provide more developmentally appropriate care. For example, teachers talked more to the children. Some stopped using walkers and swings in favor of more developmentally appropriate equipment supplied through the partnerships. In addition, many of the partnerships implemented developmentally appropriate curricula, such as the Creative Curriculum for Infants and Toddlers. As part of implementing this curriculum, teachers learned to maintain observation notes on each child. Some even developed portfolios to track children's development over time.

Providing Greater Continuity of Care. Especially in comprehensive partnerships (in which families are not subject to state child care subsidy eligibility periods), the partnerships provided families with stable child care arrangements until children aged out of Early Head Start. In subsidy enhancement partnerships, even when families temporarily lost their child care subsidies, some partnerships were able to cover brief gaps in subsidy payments to maintain continuity of care. Moreover, some partnership staff reported that they strongly encouraged parents to keep their children in the same arrangement; if necessary, staff helped mediate disagreements between parents and providers to ensure continuity of care for children.

Helping Informal Providers Obtain Licenses. Some of the Early Head Start programs we examined focused on using their partnering resources to increase the number of good-quality, infant-toddler slots available in the community. Several of these programs recruited new family child care providers, trained them, and helped them obtain licenses. Others collaborated closely with other organizations and initiatives that supported informal providers in obtaining licenses. In some technical assistance partnerships, provider liaisons approached informal providers that had been chosen by families, offered training and support, and encouraged the providers to obtain licenses.

Improving Care for Non-Early Head Start Children. In most of the partnerships we studied, the partnership agreements required that child care providers adhere to the HSPPS for all the infants and toddlers in their care. For example, many providers reduced ratios and group sizes and implemented the Creative Curriculum for Infants and Toddlers in all infant-toddler rooms, regardless of whether Early Head Start children were cared for in those rooms. Similarly, all child care teachers obtained CDA credentials and attended additional training. Thus, many of the Early Head Start program and child care staff we interviewed reported that non-Early Head Start children receiving care from the child care partners benefited from quality improvements made possible by the partnerships.

Expanding Supply and Improving Access

In many communities, the need for infant-toddler child care far exceeds the supply. Early Head Start-child care partnerships included in Year One of this study made important contributions to their communities by increasing the number of good-quality infant-toddler slots available and connecting low-income families with those slots.

Expanding the Supply of Good-Quality Infant-Toddler Slots. Some of the Early Head Start-child care partnerships created new infant-toddler child care slots that did not exist prior to the partnerships. As described earlier, some programs focused their partnership efforts on recruiting new family child care providers and supporting them in becoming licensed. Other programs partnered with child care centers that agreed to expand the number infant-toddler slots offered or reopen infant-toddlers closed because of the high cost of providing infant-toddler care.

Improving Access for Low-Income Families. The Early Head Start-child care partnerships provided an organized system that helped low-income families find and pay for good-quality, infant-toddler child care in their communities. In addition, the partnerships tried to help families sustain continuity of care for their children as long as they remained in the Early Head Start program.

Providing Transportation. In some communities, families could not access good-quality infant-toddler child care because they could not find providers located near home or work and did not have transportation to neighborhoods where providers were located. A few of the partnerships we examined provided bus transportation for Early Head Start children between their families' homes and child care providers.

Getting More Resources for Child Care Providers

The Early Head Start-child care partnerships we studied in Year One supplied child care providers with a range of resources to help them improve quality of care. Typically, providers received additional funds, toys and equipment, technical assistance, and support through the partnerships.

Increasing Funding. Partnerships supplied additional child care funds, perhaps the most important resource for a provider. The comprehensive and subsidy enhancement partnerships we examined supplied child care providers with significantly more funds than they could receive from the state child care subsidy alone. These additional funds helped providers improve the quality of care they provided and comply with the HSPPS.

Providing Developmentally Appropriate Toys and Equipment. Almost all the partnerships offered some toys, equipment, and supplies to child care providers. Provider liaisons ensured that providers had developmentally appropriate toys and equipment, and that they discontinued use of inappropriate items such as walkers and swings. In addition, programs typically supplied needed safety equipment, such as safety gates and outlet covers. Some partnerships also were able to help providers purchase or improve the safety of outdoor playground equipment.

Offering Technical Assistance and Support. All the partnerships we studied provided regular technical assistance and support to child care providers. The child care providers we interviewed generally enjoyed receiving regular visits from provider liaisons and appreciated having Early Head Start staff to turn to with questions and concerns. In particular, rural family child care providers, who said they often felt isolated in their work, appreciated the visits and support from the provider liaisons.

Increasing Community Collaboration

The Early Head Start-child care partnerships we studied in Year One pulled together a variety of community resources to support and enhance their partnerships. Early Head Start programs in several communities reported that collaboration among service providers had increased as a result of the partnerships.

Increasing Collaboration. A number of Early Head Start programs reported that, as a result of the child care partnerships, they developed relationships with community service providers that they had not worked with in the past. Early Head Start-child care partnerships collaborated with child care resource and referral agencies, community colleges, local health departments, local child care administrators, training agencies, and other community organizations. As a result of the partnerships, many of these organizations know each other better and have found opportunities to work more closely together.

Developing Comprehensive Systems of Support for Child Care Providers. Early Head Start programs drew on community resources to develop comprehensive systems of

support, technical assistance, and training for their child care partners. Often, Early Head Start provider liaisons coordinated the resources provided by other community organizations to create a system of support for child care providers. Through provider liaisons, providers had access to a range of trainers and experts in nutrition, mental health, safety, early intervention, and other areas.

Building Community Awareness of Early Childhood Issues

As Early Head Start programs engaged their communities to develop and support child care partnerships, they reported an increase in community awareness about early childhood issues and the resources required to provide good-quality infant-toddler care.

Increasing Awareness of the Importance of Good-Quality Infant-Toddler Child Care. As parents, service providers, and others in the community learned about the Early Head Start-child care partnerships, awareness of the benefits for good-quality infant-toddler care increased in some communities. In particular, some partnerships reported that many Early Head Start parents gained a better understanding of the importance of good-quality care and learned how to discern quality when they visit child care providers.

Acknowledging the Level of Resources Required to Provide Good-Quality Infant-Toddler Child Care. Partnerships reported that more child care providers in communities learned about what it takes to provide good-quality child care. They realized that child care teachers need training and small group sizes to provide developmentally appropriate care to very young children. Moreover, as child care partners, Early Head Start programs, and other community service providers worked collaboratively on the partnerships, staff from all of these organizations gained a better understanding of the resources needed to provide good-quality infant-toddler care.

Emerging Themes: Challenges Faced by the Partnerships

Despite the successes Early Head Start-child care partnerships achieved, many partnerships reported significant challenges. Depending on the community context in which partnerships were implemented and the resources available to support them, some partnerships succeeded in implementing certain aspects of the HSPPS (such as child-teacher ratios and group-size requirements), while others faced significant challenges in the same areas. In particular, some programs reported challenges in improving child care quality, achieving compliance with the HSPPS, maintaining continuity of care for children, providing sufficient care to meet families' needs, and staffing issues. In the rest of this section, we describe each of these challenges in greater detail.

Improving Quality and HSPPS Compliance

A number of factors—including state regulations, community characteristics, and available resources—have made improving quality and complying with the HSPPS challenging in some communities.

Reconciling Differences Between State Licensing Requirements and the HSPPS. Early Head Start programs reported that it took time for some providers to view the state licensing requirements as minimal health and safety requirements, rather than standards for good-quality care. Some providers were confused by differences between the state licensing requirements and the HSPPS, and they viewed exceeding the state requirements as voluntary and sometimes unnecessary. This was especially true for providers in technical assistance partnerships that did not provide sufficient resources to cover costs associated with meeting the HSPPS.

Covering Costs Associated with Meeting the HSPPS. In some states, licensing requirements place no limit on group size. In others, child-teacher ratio requirements are higher—especially in family child care homes and for toddlers in centers—than those required by the HSPPS. In these states, child care providers often could not afford to make the required changes, unless the Early Head Start program could cover the costs associated with reducing group sizes and ratios. This was true regardless of whether providers viewed the changes as necessary.

Coping with Differences in Philosophy and Organizational Culture. Some partnerships reported problems stemming from differences in philosophy and organizational culture. For example, some Early Head Start programs partnered with for-profit child care centers whose directors were reluctant to make changes that could increase their costs. Similarly, programs reported that some partners did not share their commitment to providing services to low-income families. Because of the tremendous need for infant-toddler child care in their communities, some child care providers objected to quality improvements (especially reducing group sizes and child-teacher ratios) that may have required them to serve fewer children. Programs tried to iron out these differences by building strong relationships and encouraging dialogue between partners. However, some programs eventually terminated partnerships with child care providers who did not share their goals. Some limited new partnerships to providers with similar philosophies, such as other nonprofit agencies serving similar populations.

Addressing Child Care Teacher Turnover. In some communities, child care teacher turnover was high because teachers can find higher-paying jobs in other fields that do not require additional training (in contrast to the CDA training required by the HSPPS). When teachers left and new ones were hired, provider liaisons had to "start over" with the new teachers—on building relationships, providing training on the HSPPS, and helping them obtain a CDA credential. Frequent teacher turnover also disrupted continuity of care. To address these problems, some comprehensive and subsidy enhancement partnerships offered incentives, such as movie tickets, dinners, and bonuses, to teachers who stayed in

their jobs. Others offered bonuses and salary increases to teachers who obtain a CDA credential.

Helping Teachers Obtain CDA Credentials. For some child care teachers, obtaining a CDA credential in one year was challenging, although many were able to meet this requirement. Some teachers, especially those who had young children of their own, found it difficult to work full time and attend CDA classes during evenings and weekends. In one community, program staff reported that many family child care providers needed to obtain a GED before they could begin CDA training. Obtaining a GED and then a CDA credential often takes longer than one year. In technical assistance partnerships, programs encouraged child care teachers to obtain CDAs, but programs typically did not have funds to compensate teachers for time in training or provide significant financial incentives. Consequently, technical assistance partnerships had limited success in convincing teachers to complete CDA training.

Implementing the HSPPS in Family Child Care Homes. Most states allow family child care providers to care for more than four children. Convincing providers to reduced their groups to four children was challenging, especially when the partnerships could not compensate for the loss of income associated with reducing group size. Implementing other standards, such as posting procedures and rules, was also challenging in home settings. Programs worked with family child care providers to develop creative solutions, for example, by laminating procedures and hanging them on doors during child care hours.

Adjusting to Increased Workloads for Teachers. Early Head Start-child care partnerships increased the workload of child care teachers. In some cases, teachers were reluctant or slow to implement additional duties. For example, some partnerships required child care teachers to implement new curricula and maintain observation notes on all the children in their care. Others required teachers to develop portfolios for children. In some partnerships, child care teachers were asked to hold two parent-teacher conferences and conduct two home visits with families each year.

Maintaining Continuity of Care

The HSPPS require programs to ensure stability in child care arrangements so that continuity of care for children is maintained. Stable child care arrangements in which children can form strong attachments to a limited number of caregivers contribute positively to children's development. However, in addition to problems with child care teacher turnover described above, some programs have faced challenges in maintaining the continuity of child care arrangements.

Dealing with Gaps in State Child Care Subsidy Eligibility. Children enrolled in Early Head Start maintain their eligibility for a year or more. However, the eligibility period for state child care subsidies usually is much less than one year, so families can lose their eligibility for subsidies well before the end of their Early Head Start eligibility. Families lose eligibility for subsidies for a variety of reasons, including parent job loss, gaps between

training programs or other work activities, or a range of problems related to subsidy administration. Regardless of the reason, loss of the child care subsidy can result in loss of child care arrangements unless partnerships have alternative funding sources to pay for care. Thus, when families lost eligibility for state child care subsidies, partnerships were sometimes unable to maintain continuity of care for children.

Transitioning Out of Early Head Start. When children age out of Early Head Start, maintaining continuity of care can be difficult. Some families wanted to keep their child with the same child care provider after they left Early Head Start, but they could not afford the provider's fees without the funding provided through the partnership. Providers in a few partnerships were able to create sliding-fee scales for these families. Sometimes, however, families had to move their child to a lower-quality child care setting that they could afford, either by paying the fees on their own or using the state child care subsidy.

Recruiting Providers That Meet Families' Needs

The need for infant-toddler child care far exceeds the available supply of care in most communities. In some communities, Early Head Start programs had difficulties finding enough child care partners, especially those with convenient locations offering care during hours that match parents' work schedules.

Identifying and Recruiting Interested Providers. For some programs, recruiting child care providers willing to work toward meeting the HSPPS was challenging. Provider recruitment was especially difficult in rural areas, where child care providers tend to be scarce and geographically dispersed. One program that recruited family child care providers in an urban community also had difficulty finding providers in some low-income neighborhoods. In general, programs that offered fewer financial incentives for partnering (such as those operating technical assistance partnerships) had greater difficulty recruiting child care providers.

Matching Families with Conveniently Located Providers. Matching families with providers was particularly challenging in some rural areas, where child care providers, families' homes, and parents' work places were far apart. In addition, some programs found that, although many families lived and worked in small communities, most child care providers were located in urban areas. Programs that partnered primarily with family child care providers found they were sometimes not located near where families lived or worked, either in urban or rural areas.

Matching Families with Providers That Offered Care During Nonstandard Work Hours. A few programs told us that they could not accommodate some families' child care needs, because parents worked during nonstandard hours, such as evenings or weekends, when their child care partners were not open. Few of the partnerships we examined included child care providers that stayed open during these hours. Some programs referred these families to CCR&Rs for help in finding child care and offered to provide Early Head Start services to the families through the home-based option.

Addressing Staffing Concerns

The success of the Early Head Start-child care partnerships depends on establishing solid relationships between partners, with clear lines communication and supervision. In some partnerships, staffing issues surfaced which posed challenges for maintaining strong partnerships.

Maintaining High Morale Among Program Liaisons. High teacher turnover and slow progress toward achieving the HSPPS led to low morale for some provider liaisons, who felt they should have seen larger quality improvements from their heavy investments of time and energy In addition, some liaisons were overwhelmed by their responsibilities and did not have enough time to spend with each child care partner. Some liaisons had to reduce both the number of visits they made to partners and the intensity of support they offered.

Supervising Staff. Early Head Start programs are responsible for ensuring that the child care settings in which they place children meet the HSPPS. Provider liaisons and education coordinators, however, do not directly supervise the child care teachers who work for their child care partners. They can make suggestions and encourage teachers to implement certain approaches, but they cannot tell child care staff that they must change their practices. To address this problem, programs found that making their contracts with providers as specific as possible gave them more leverage to ask that teachers change certain behaviors (for example, using walkers). In addition, some programs placed their own staff in child care centers. In some cases, programs found supervising and supporting these off-site staff difficult.

CONCLUSIONS

The successes and challenges highlighted in this chapter demonstrate the complexities of implementing child care partnerships. They also demonstrate the diversity of community contexts in which partnerships have been implemented and the implications of those community differences. Depending in part on community characteristics—the local supply of child care, other initiatives available to support the partnerships, state regulations, and subsidy policies—and the resources available to pay for child care, the partnerships we studied in Year One succeeded or faced challenges in implementing the HSPPS. As we expand our data collection activities in Year Two, we will examine these successes and challenges, as well as new themes that emerge, in more depth.

In the next chapter, we highlight preliminary operational themes derived from the experiences of the Early Head Start-child care partnerships we studied in Year One. By examining the successes achieved by these partnerships, as well as the challenges they faced, we have identified preliminary themes for states, communities, and programs on ways in which they can support and strengthen similar collaborative efforts.

CHAPTER IX

EMERGING THEMES: SUPPORTING CHILD CARE PARTNERSHIPS

The experiences of the Early Head Start-child care partnerships can help guide policymakers and program administrators as they design and implement new initiatives to increase low-income families' access to good-quality infant-toddler child care. From focus groups, telephone interviews, and a literature review conducted during Year One of the study, we have derived a number of preliminary operational themes about designing, implementing, and supporting child care partnerships. In particular, the chapter focuses on preliminary themes that relate to federal and state policymakers and administrators, communities, and new partnerships. As we broaden the scope of our data collection activities in the study's next phase, these preliminary themes may evolve and new themes may emerge.

EMERGING THEMES FOR FEDERAL POLICYMAKERS AND PROGRAM ADMINISTRATORS

Support from federal policymakers and program administrators is essential to the success of child care partnerships. The Head Start Bureau has encouraged community collaboration for many years, and since 1997 has promoted the use of partnerships with child care providers to provide full-day, full-year services to families who need them. In 1998, the Child Care and Head Start Bureaus launched the Quality in Linking Together: Early Education Partnerships (QUILT) initiative to provide technical assistance to Head Start and Early Head Start programs and child care providers in developing partnerships. Federal policymakers and program administrators may be able to further support partnerships by coordinating rules and procedures for programs that fund infant-toddler care and education, encouraging states to implement policies that support partnerships, and streamlining reporting and record-keeping requirements for programs and providers that combine multiple funding streams.

Increasing Coordination at the Federal Level to Align Program Standards and Requirements for Programs that Fund Infant-Toddler Care. Coordinating rules and

procedures across programs and funding streams can help support continuity of care and reduce confusion among child care providers. For example, program eligibility requirements and periods could be aligned to ensure that child care funding—and, thus, the child care arrangements children are in—remain stable. In addition, aligning quality standards and regulations across initiatives could reduce confusion at the local level about which set of requirements to follow.

Encouraging States to Implement Policies that Support the Partnerships. Encouraging states to align rules and procedures across programs could also be helpful. In recent years, the Child Care and Head Start Bureaus already have taken some steps to encourage states to move in this direction. For example, in 1999, the Child Care Bureau issued an information memorandum to states clarifying that they can align the eligibility and recertification periods for child care subsidies funded through CCDF with Early Head Start, Head Start, or pre-kindergarten programs (Administration for Children and Families 1999b). Similarly, in 2001, the Child Care and Head Start Bureaus sent a joint communication to states encouraging them to blend funding across programs and align planning for initiatives funded by CCDF and Head Start to work on increasing the supply of infant-toddler care, improving child care quality, and providing professional development opportunities to child care teachers (Administration for Children and Families 2001a).

Coordinating and Streamlining Record-Keeping and Reporting Requirements to Ease the Paperwork Burden Associated with Combining Funding Streams. When Early Head Start, child care providers, and other local initiatives blend multiple funding streams, they must adhere to the record-keeping and reporting requirements of several funding sources. Simplifying and aligning financial management requirements to reduce paperwork and avoid duplication of effort in reporting to each funding source could be helpful. In early 2001, the Head Start Bureau took some steps toward simplifying these management requirements by issuing an information memorandum to Head Start grantees that clarifies cost allocation requirements (Administration for Children and Families 2001b).

Emerging Themes for State Policymakers and Program Administrators

States can play a significant role in the success of child care partnerships by implementing policies and procedures that support the partnerships' goals. In particular, state policy and program changes could increase funding available to the partnerships, ensure continuity of care for infants and toddlers served through the partnerships, and help partnerships achieve and sustain high quality standards for infant-toddler child care. The rest of this section describes policies and procedures that states could implement to support the partnerships.

Aligning Eligibility Periods for State Child Care Subsidy and Other Programs to Promote Continuity of Care for Children. Unless partnerships have alternative funding sources to pay for care, children who lose subsidy eligibility are at risk of losing their child care slots. States can help partnerships provide stable child care arrangements for children

by aligning the eligibility periods for state child care subsidies and other programs, such as Early Head Start for these children.

Providing a Full-Day Subsidy for Children Enrolled in the Partnerships, Even When Other Programs Pay for a Portion of the Cost of Care. Some states provide only a partial-day subsidy for children when Early Head Start or other grant funds pay for part of the cost of a day's care. Early Head Start-child care partnerships in these states must provide a partial day of Early Head Start services and a partial-day of "wrap-around" child care services. These wrap-around services are sometimes of lower quality because the state subsidy is not high enough to provide care that meets the HSPPS. Many states, however, allow Early Head Start-child care partnerships to use a "wrap in" method of allocating costs, in which they use the state child care subsidy to pay for a full day of child care, while Early Head Start funds are used to increase the quality of care throughout the day. When states use the latter approach, partnerships have more resources and may be better able to work on meeting the HSPPS.

Providing State Child Care Subsidy Funds to Early Head Start Programs in the Form of Grants to Fund Care Provided Through Child Care Partners. Partnerships in some states reported that providers had to wait a long time to receive subsidy payments from the state. As a result, some experienced cash flow problems and difficulties maintaining their businesses. Others were reluctant to accept subsidized children and maintain their partnerships with Early Head Start programs. To address this problem and provide a stable source of funds for the partnerships, states could provide subsidy funds in the form of grants to the Early Head Start or other programs working with child care providers. Programs could administer the funds and pay providers on a regular schedule. Some states already provide Early Head Start programs with grants from subsidy funds to pay for care provided in Early Head Start child care centers.

Using TANF Transfers and Other State Funding Sources to Support the Partnerships. Some states, such as Kansas and Missouri, already provide funding from sources other than CCDF to support Early Head Start-child care partnerships. When states use TANF transfers and other types of state funding, families are not subject to the state's child care subsidy eligibility period; partnerships can provide child care for as long as families are eligible for Early Head Start. In addition, funding levels are not limited to 75 percent of market rates, allowing states to fund the partnership at levels required to meet the HSPPS.

Offering Higher Reimbursement Rates to Providers as an Incentive for Entering Partnerships. Many states offer tiered subsidy rates as an incentive to promote certain types of child care. For example, higher subsidy rates may be paid to providers that are accredited, offer infant care, or supply care during evenings and weekends. Higher subsidy rates for providers in partnerships formed to increase supply and improve quality would not only promote the formation of partnerships; they would also acknowledge the additional costs associated with providing higher-quality care.

Providing Technical Assistance and Support to Partnerships. States can support partnerships by providing them with technical assistance and convening them regularly to discuss state policies and procedures on subsidies and early childhood programs. States could also use the CCDF quality set-aside to provide technical assistance to partnerships and ensure that partnerships have access to training and other resources offered through state quality initiatives.

Emerging Themes for Communities

As the need for infant-toddler child care has increased under welfare reform, and more people have become aware of the importance of early childhood development, community efforts to coordinate early childhood services and advocate for state policies to improve child care quality and increase supply have expanded. For example, some city governments have opened child development offices to coordinate services and advocacy initiatives. Many community coalitions have formed and have become more vocal advocates of various child care policy initiatives. This section describes several ways in which community collaborative groups and organizations can support child care partnerships.

Advocating for State Policies that Facilitate Partnerships. These policies include aligning eligibility for state child care subsidies and other programs; providing partnerships with full-day subsidies, higher subsidy reimbursement rates, and grants from subsidy funds; and drawing on other state sources of revenue to fund the partnerships.

Blending Funding to Serve More Children, Increase Hours of Care Available, and Improve Quality. Resources from community, city government, or state early childhood initiatives can be combined with Early Head Start or other resources to provide care that meets the HSPPS to as many low-income infants and toddlers as possible. Combining funds may help providers extend hours of care to serve children for a full day or during evenings and weekends. Blended funding arrangements may also support more intensive training and support to infant-toddler child care teachers, as well as higher wages.

Promoting Collaboration Among Early Childhood Programs and Professional Development Initiatives for Child Care Teachers. Through funding sources such as the CCDF quality set-aside and the Healthy Child Care America initiative, projects are under way in many communities to provide early childhood education to low-income children; education and training to child care teachers; and offer a range of health, nutrition, and early intervention services to low-income families. Sometimes, however, these initiatives are fragmented and disconnected from one another. Communities can promote collaboration across the Early Head Start and child care communities and coordination across the child care, early childhood education, child health, and professional development initiatives operating locally. Collaboration can increase the resources available to support the partnerships and reduce duplication of effort across initiatives.

EMERGING THEMES FOR NEW PARTNERSHIPS

Developing partnerships is a relatively new strategy implemented by Early Head Start programs and child care providers to meet the child care needs of low-income families with infants and toddlers. Programs and child care providers seeking to form partnerships for the first time can learn from the experiences of more established partnerships. This section describes preliminary operational themes derived from the experiences of Early Head Start programs and child care providers in the partnerships we examined.

Recruiting Partners Before Placing Children in Care, Rather than Approaching Providers After They Have Begun Serving Children. The comprehensive and subsidy enhancement partnerships we examined typically recruit child care partners and negotiate partnership agreements prior to placing Early Head Start children in care. This process occurs over several months, during which the partners get to know each other and develop a common understanding about the obligations of the partnership. Partnerships reported that solidifying these initial relationships before placing children in care has been crucial to their success. In technical assistance partnerships, programs often approach providers after they begin caring for Early Head Start children and ask providers to form partnerships with them. Programs reported that some providers have been reluctant to form these technical assistance partnerships, and that progress toward meeting the performance standards has been slow.

Forming Partnerships with New Family Child Care Providers that Are Willing to Care for Four or Fewer Children. In many states, licensing requirements for family child care homes permit providers to care for more than four children (the limit set by the HSPPS). In other states, licensing for family child care homes is optional or there is no limit on group size. Programs in these states reported limited success in recruiting established family child care providers as partners. Often, the program cannot afford to compensate providers for the loss of revenue that would result from reducing their group size to four children. In these states, therefore, programs could consider recruiting new family child care providers that are interested in caring for small groups of children (four or fewer) as partners, training them, and helping them become licensed.

Forming Partnerships with Center-Based Providers that Share the Program's Mission of Serving Low-Income Families. Limiting new partnerships to providers that have similar philosophies and organizational cultures, and that already serve similar populations, may increase success. Partnerships with for-profit centers that are reluctant to make changes that would increase costs, or with providers that do not share a commitment to serve low-income families may be more difficult to establish and sustain.

Working Together to Building Strong Relationships. Staff from the partnerships we studied stressed that strong relationships between partners lie at the heart of the partnerships. Strong relationships enable partners to trust each other, communicate clearly about roles and expectations, and resolve problems and differences that come up. Partners must treat each other as equals and value the contribution that each makes to the

partnership. Moreover, when partners view each other as supportive and friendly, they are more likely to seek consultation and help from one another when difficulties arise with children and families.

Acknowledging that It Takes Time to Make Changes Necessary to Improve Quality. Most child care providers are not prepared to comply with the HSPPS immediately. Many must make numerous changes to comply with the standards, and they cannot make all of the changes at once. Although purchasing equipment and making structural changes to the caregiving environment can be accomplished relatively quickly, helping child care teachers change their approach with children takes longer. Teachers need training, mentoring, and help implementing new curricula. In recognition of the time needed to make these changes, some partnerships develop goal plans that outline specific steps to be taken toward meeting the HSPPS and timetables for completing each step.

Reassuring Child Care Partners that Early Head Start Does Not Intend to "Take Over" the Partner's Business, But Is There to Help the Partner Work on Improving Quality. Initially, some child care providers in the partnerships we studied felt overwhelmed by the partnerships and the many requirements of the HSPPS, which makes it difficult for partners to build relationships and communicate effectively. Child care partners need to be assured that Early Head Start does not want to overpower the partner's business or its identity. Rather, the program's goal is to provide training, technical assistance, and resources to support the provider in working toward higher quality.

Clarifying Lines of Authority, Communication, and Supervision When Staff from Different Organizations Are Co-Located. In some partnerships, programs place their own staff in partners' child care centers or house staff from other community partners in their offices. While these arrangements work well for some, for others they lead to confusion about lines of authority and supervision. Staff are sometimes uncertain who should perform what tasks. When staff from multiple organizations are co-located, partners should provide close supervision and communicate clearly about division of duties and lines of authority.

Recognizing Partners' Achievements. Complying with the HSPPS is hard work for child care providers. When partnerships begin, the standards can seem overwhelming. Teachers must obtain CDAs, room arrangements must be altered, new curricula must be implemented, and new equipment must be purchased. Child care partners need encouragement and recognition for their achievements, for example through awards or social gatherings to celebrate important accomplishments. Acknowledging achievements also may help provider liaisons appreciate the improvements they are helping providers make.

Hiring Provider Liaisons that Have Strong Interpersonal Skills and Expertise in Infant-Toddler Issues. Liaisons between programs and child care partners need to be diplomatic and friendly to interact effectively with partners. They should also be able to bridge organizational differences and work constructively on common goals. Expertise in early childhood development helps them provide technical assistance to providers.

Developing Detailed Contracts that Clearly Communicate Expectations. Early Head Start programs must ensure that child care provided through the partnerships meets the HSPPS. Program staff, however, do not directly supervise child care teachers. While they can make suggestions, provide training, and model developmentally appropriate approaches to caregiving, they cannot tell child care teachers that they must implement specific practices. Including specific requirements for child care settings and teacher responsibilities in contracts with providers can make expectations clearer and give programs more leverage in working with them to make changes.

Involving Both Partners in Developing Partnership Agreements. Partnership agreements document the expectations of both partners, the resources each party will bring to the partnership, and the activities that each agrees to carry out. Involving both parties early on in contract development helps ensure that both child care partners have a better understanding of their obligations to meet the HSPPS and the resources programs can offer. Similarly, early involvement helps program staff understand providers' needs and expectations.

Concentrating Resources on Fewer Partnerships Initially. While many of the Early Head Start programs we contacted have developed multiple partnerships with both child care centers and family child care homes, some programs have concentrated their resources in only two or three partnerships. Especially when programs form partnerships for the first time, working intensively with one or two trusted child care partners allows programs to gain experience that will help later partnerships. Some programs have developed their first partnerships with "in-house" partners, usually child care centers operated by the sponsoring agency but not part of the Early Head Start program.

Establishing an Emergency Fund to Cover Short-Term Gaps in Subsidy Payments. In many of the partnerships we studied, some families lost their eligibility for state child care subsidies, at least temporarily. When families cannot pay for care, children may lose their child care slots. Establishing emergency funds to pay for care during short-term gaps in subsidy coverage can help sustain continuity of care for children in these circumstances. To cover these costs, many partnerships use Early Head Start funds or private funds from United Way or other sources.

Seeking Outside Funding Sources to Fund the Partnerships. Costs associated with providing full-time child care in compliance with the HSPPS usually exceed funding available from the Early Head Start grant or state child care subsidy systems alone. Partnerships typically combine funding from these sources. They may also need to seek funding from private funders, such as United Way, and state resources, such as TANF transfers or tax revenues.

Conclusions and Next Steps

Preliminary evidence from the study's first year indicates that Early Head Start-child care partnerships can be successful in helping low-income families find good-quality child

care arrangements for their infants and toddlers. Some of these partnerships are mobilizing federal, state, and community resources to help child care providers improve quality of care. Many of the partnerships we examined reported improvements in key structural features of partners' child care settings that research has shown to be closely associated with positive child outcomes. Moreover, partnerships can connect families who need infant-toddler child care with good-quality, stable care that meets the developmental needs of very young children and supports their working parents. As more partnerships and collaborations emerge to address the growing need for good-quality care, policymakers and program operators can learn from the promising practices identified in this study.

In the next phase of the study, we will develop in-depth case studies of collaborative infant-toddler child care initiatives located in three diverse communities. We will include Early Head Start-child care partnerships, as well as other community-based initiatives and partnerships. Through these case studies, we expect to explore the emerging themes described in this interim report in more depth and to identify new themes. Based on these themes, we will formulate operational lessons that can inform the decisions of a wide range of policymakers and program operators as they seek to help low-income families access good-quality child care for their infants and toddlers.

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Appendix A

Telephone Interview and Focus Group Discussion Guides

TABLE A.1

DISCUSSION GUIDE FOR TELEPHONE INTERVIEWS WITH KEY INFORMANTS

Key Topics	Detailed Questions and Discussion Points
Introduction	
Introduce team members	Introduce MPR and ZERO TO THREE staff participating in the interview
Describe study	We have been funded by the Child Care Bureau of the Administration for Children, Youth and Families to conduct a study to identify barriers low-income families face in arranging good-quality child care for their infants and toddlers and promising community strategies that have been implemented to overcome those barriers. We expect to release a Year One report in fall 2001 that describes the community strategies we have learned about. We hope to receive funding to develop case studies about a select number of specific community strategies in Year Two.
Purpose of interview	We are talking to some key people in the child care and early childhood education fields before we begin the bulk of the focus groups and telephone interviews, to make sure we include the key issues and talk to the right group of people. Want to discuss three main topics with you: --changes since welfare reform in the barriers low-income families face to arranging good-quality child care for their infants and toddlers --community strategies for overcoming the barriers --recommendations for other people we should talk to and communities we should include in the study
Barriers	
What has changed since welfare reform about the barriers low-income families face in arranging good-quality infant-toddler child care?	Supply of good-quality infant-toddler child care? Supply during non-standard hours? Supply of care for infants and toddlers with special needs? Supply for infants versus toddlers?
	Cost of good-quality infant-toddler child care? Subsidy systems? Waiting lists? Uptake? Administration of subsidies? Subsidy levels? Interruptions in care due to interruptions in parents' employment?
	What is the availability of information to help parents arrange good-quality infant-toddler care?
	Is finding qualified child care staff a barrier?
	Other barriers such as transportation, language or cultural barriers?
	Which of these barriers do you think can be most readily resolved? Which ones seem intractable?
	What impact has welfare reform had on these barriers, either positive or negative?

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TABLE A.1 (*continued*)

Key Topics	Detailed Questions and Discussion Points
Strategies	
Describe innovative strategies that you are aware of for improving the supply of good-quality infant-toddler child care. Are you aware of innovative strategies for developing new providers of good-quality infant-toddler child care? For improving the quality of infant and toddler care provided by relatives and other "kith and kin" providers?	Who is "at the table" in communities implementing these strategies? Who is leading these efforts? In what ways are the Early Head Start and child care communities coming together at the local level to work on quality?
	How long have these efforts been going on?
	What has been accomplished so far? Which strategies do you think have been most effective?
	Who else should we talk to about these efforts?
Describe strategies for helping families pay for good-quality infant toddler care. Are you aware of strategies to help families maintain good-quality care during interruptions in subsidies caused by interruptions in parents' employment?	Who is "at the table" in communities implementing these strategies? Who is leading these efforts? In what ways are the EHS and child care communities coming together to help families pay for care?
	How long has this effort been going on?
	What has been accomplished so far? Which strategies do you think have been most effective?
	Who else should we talk to about these efforts?
What are main challenges to implementing collaborative initiatives or partnerships on the local level?	Do the various funding streams available to pay for infant and toddler care pose challenges to community collaboration?
	Do differences in state licensing standards and other program requirements (such as the Head Start Performance Standards) create challenges to collaboration?
	Does competition for qualified staff create challenges to collaboration?
	What have communities done to overcome these challenges? Which strategies have been most effective?
Other Sources of Information	
Do you have recommendations for other people we should talk to about these issues?	Name, contract information, area of expertise, role in infant-toddler initiatives
Do you know of communities that are implementing innovative strategies to address the barriers low-income families face to accessing good-quality infant-toddler child care? Who are the key people involved?	Location, overview of initiative, key players, contact information

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TABLE A.2

FOCUS GROUP DISCUSSION GUIDE

Key Topics	Detailed Questions and Discussion Points
Introduction	
Introduce team members	Introduce MPR and ZERO TO THREE staff leading the focus group
Describe study	We have been funded by the Child Care Bureau of the Administration for Children, Youth and Families to conduct a study to identify barriers low-income families face in arranging good-quality child care for their infants and toddlers and promising community strategies that have been implemented to overcome those barriers. We expect to release a Year One report in fall of 2001 that describes the community strategies we have learned about. We hope to receive funding to develop case studies about a select number of specific community strategies in Year Two.
Purpose of discussion	We are here today to hear about the barriers faced by low-income families in your communities and strategies that communities have implemented to help families arrange and pay for good-quality care for infants and toddlers. Through these focus groups we hope to identify a select number of communities that have implemented promising strategies to study in-depth during the second year of the study.
Procedures for the Discussion	
Taping	We will be taping the discussion, so we need to be sure to speak one at a time, speak loudly, and speak clearly.
Confidentiality	Everything said here is confidential. No names will be associated with the results. No one will be quoted by name.
Offer opinion even if different from others	There are no right or wrong answers. People may disagree, and that's okay. Please feel free to offer your opinions, whether positive or negative.
Time restrictions—moderator must move discussion to cover all topics	We have a number of topics we want to discuss. At times, I may need to move the conversation along to be sure we cover everything.
Logistics	Point out refreshments and restrooms
Questions	Any questions before we get started?
Introductions	
Participant introductions	Let's begin with introductions. Please tell us your first name, where you are from, your position, and the type of agency you work for.

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TABLE A.2 (*continued*)

Key Topics	Detailed Questions and Discussion Points
What barriers do low-income families in your community face in accessing good-quality child care for their infants and toddlers? (20 minutes)	
Supply	What types of arrangements are available in your community for infants and toddlers?
	What types of arrangements do low-income families typically use for their infants and toddlers?
	Is the supply of infant and toddler care adequate in your community? Supply for infants? Supply for toddlers? Is the supply of infant and toddler care adequate during nonstandard work hours (early morning, evening, overnight, weekend) adequate? Is the supply of care for infants and toddlers with special needs adequate?
	Has welfare reform had an impact of the supply of child care for infants and toddlers in your community? How?
Cost	What is the cost of infant and toddler child care in your community? For infants? For toddlers?
	Are child care subsidy funds available for TANF recipients? Families leaving TANF? Low-income working families who do not receive TANF? - Are subsidy levels adequate for cover the cost of infant and toddler care for each of these groups? - Is there a separate subsidy system for TANF, transitional, and non-TANF families? If so, is the transition from TANF to non-TANF smooth or difficult? - Do TANF or non-TANF families who need child care subsidies have to go on a waiting list until funds become available? If yes, how long do families typically have to wait? - To what extent to low-income families know that child care subsidies are available? - Are there notable aspects of the subsidy system that facilitate or hinder low-income families' access to infant and toddler child care? (PROBES: application process, eligibility determination, system for paying providers, documentation requirements) - When parents are temporarily between jobs, do families lose their child care subsidies? Does this cause interruptions in child care arrangements? When parents begin working again, do families have to reapply for the subsidy? Do they have to go on a waiting list? For how long?
	Are there other sources of funding available in your community to help low-income families with infants and toddlers pay for child care?
Quality	What is the quality of infant and toddler child care in your community? Are there differences in the quality of infant and toddler care? (PROBE: What is your definition of quality?)
	What types of child care arrangements do low-income parents in your community prefer for their infants and toddlers? Do parents prefer different types of arrangements for infants versus toddlers? Why?
	What is the supply of good-quality infant and toddler child care in your community? What is the supply of infant and toddler care that meets parents' preferences?

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TABLE A.2 (*continued*)

Key Topics	Detailed Questions and Discussion Points
Information	What is the availability of information and resources to help low-income parents arrange child care for infants and toddlers in your community? (PROBES: How do parents typically search for infant and toddler child care? Is there a resource and referral agency in your community? How does it work? Do low-income parents use it? What outreach methods does the R&R use to inform low-income families of child care options?)
Other Barriers	Are there other barriers that low-income families face to arranging good quality child care for their infants and toddlers in your community? (PROBES: Transportation, language or cultural barriers to accessing care, barriers to arranging care that provides linguistic and cultural continuity between home and child care, others?)
Strategies (20 minutes)	
What strategies have been implemented in your community to improve the quality of infant and toddler child care used by low-income families?	Describe the strategies implemented in your community to improve the quality of infant and toddler child care used by low-income families. - Who has been involved in this effort? (PROBES: child care providers, resource and referral agencies, Early Head Start, child care subsidy administrators, welfare administrators, licensing agencies, community organizations, other non-profits?) - Who is leading the effort? - How long has this effort been going on? - What has been accomplished so far?
	Has your community received funding or other support from state, local, or other sources for efforts to improve the quality of infant and toddler child care?
	Have specific community strategies been implemented in your community to develop and support new providers of good-quality infant and toddler child care?
	Have specific community strategies been implemented to improve the quality of infant and toddler care provided by relatives and other "kith and kin" providers?
What strategies have been implemented in your community to help families pay for good-quality infant and toddler care? (15 minutes)	Describe the strategies implemented in your community to help families pay for good-quality infant and toddler child care? - Who has been involved in this effort? (PROBES: child care providers, resource and referral agencies, Early Head Start, child care subsidy administrators, welfare administrators, licensing agencies, community organizations, other non-profits?) - Who is leading the effort? - How long has this effort been going on? - What has been accomplished so far?
	What strategies have been developed to help families maintain good-quality care during interruptions in employment?

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TABLE A.2 (*continued*)

Key Topics	Detailed Questions and Discussion Points
What challenges do child care providers and other agencies serving low-income families with infants and toddlers in your community face in implementing collaborative initiatives or partnerships to increase low-income families' access to good-quality infant and toddler care? (15 minutes)	Do the various funding streams available to pay for infant and toddler child care (federal, state, local) create challenges to community collaboration? (PROBE: Have the various funding streams for child care created competing systems for infant and toddler care?)
	Do differences in state licensing standards and other program requirements and standards (such as the Head Start performance standards) created challenges to community collaboration?
	Do child care providers and other organizations serving families with young children compete for qualified staff?
	What has your community done to overcome these challenges? Which strategies have been effective?
	Have there been differences in challenges to increasing access to infant versus toddler care?
Has your community worked with the state to access funding and/or develop policies that address the needs of low-income families with infants and toddlers for affordable, good-quality care? (10 minutes)	What strategies have been implemented in your community to influence state child care subsidy policies? Differences in policies for infant versus toddler care?
	What strategies have been implemented in your community to influence other state or local child care policies or procedures?
	Has your community applied for state or other funds for collaborative initiatives for improving low-income families' access to good-quality infant and toddler child care? If yes, what kinds of activities do these funds support?
Wrap Up	
As I mentioned at the beginning of the discussion, we wanted to hear from you about the barriers that low-income families in your communities face to accessing good-quality infant and toddler care and the strategies that your communities have implemented for helping families access and pay for good-quality care. (5 minutes)	Is there anything else about infant and toddler-child care in your community that you would like to share before we close?

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TABLE A.3

DISCUSSION GUIDE FOR TELEPHONE INTERVIEWS WITH STATE-LEVEL INFORMANTS

Key Topics	Detailed Questions and Discussion Points
Introduction	
Introduce team members	Introduce MPR and ZERO TO THREE staff participating in the interview
Describe study	We have been funded by the Child Care Bureau of the Administration for Children, Youth and Families to conduct a study to identify barriers low-income families face in arranging good-quality child care for their infants and toddlers and promising community strategies that have been implemented to overcome those barriers. We expect to release a Year One report in fall 2001 that describes the community strategies we have learned about. We hope to receive funding to develop case studies about a select number of specific community strategies in Year Two.
Purpose of interview	To learn about specific strategies being implemented in [COMMUNITY/STATE] to improve low-income families' access to good quality child care for their infants and toddlers.
Confidentiality	If there is anything we discuss today that you would like me to keep confidential and make sure could not be attributed to you or your organization or community, please let me know. In general, our report will contain general information about strategies and summarize the challenges and successes we learn about across the communities we are studying. Comments made during the interviews will not be attributed to specific individuals.
Strategies	
We are particularly interested in learning about X strategy in your state/community X.	Can you give me an overview of [STRATEGY]?
	Who Is at the table in communities implementing [STRATEGY]?
	Who is leading the effort?
	How long have these efforts been going on?
	How was this strategy developed? By whom?
	Was this strategy developed to address specific barriers to low-income families' access to good-quality infant-toddler care? If yes, which barriers?
	What has been accomplished so far? What do you think has made this strategy effective?
	Has this strategy led to new partnerships or new areas of collaboration in the community? If yes, who is involved?
Has this strategy led to new funding sources for infant-toddler care in your community?	If yes, which funding sources?
	Has this new funding increased the number of good-quality infant-toddler slots available in your community?
	Approximately how many slots?
	Has this new funding extended the hours during which care is available?
	Has this new funding improved the quality of infant-toddler child care that is available?

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TABLE A.3 (*continued*)

Key Topics	Detailed Questions and Discussion Points
What has been challenging about implementing this strategy?	Have there been challenges to community collaboration? To forming new partnerships?
	Has combining funding streams to pay for infant-toddler care been challenging?
	Have differences in standards and requirements for various funding streams caused challenges?
	Have there been delays in implementing the strategy?
	What has been done to overcome these challenges? Which approaches to overcoming the challenges have been most effective?
Who else should we talk to about these efforts?	Name, contact information, role
Other Strategies	
Are there other strategies being implemented for improving low-income families' access to good-quality infant-toddler care?	If yes, ask relevant questions from previous section.
Barriers	
Are there other significant barriers in your community to low-income families' access to good-quality infant-toddler care that we have not discussed?	If yes, what are they? How is your state/community addressing these barriers?

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TABLE A.4

DISCUSSION GUIDE FOR TELEPHONE INTERVIEWS WITH EARLY HEAD START-CHILD CARE PARTNERSHIPS IN MISSOURI

Key Topics	Detailed Questions and Discussion Points
Introduction	
Introduce team members	Introduce MPR and ZERO TO THREE staff participating in the interview
Describe study	We have been funded by the Child Care Bureau of the Administration for Children, Youth and Families to conduct a study to identify barriers low-income families face in arranging good-quality child care for their infants and toddlers and promising community strategies that have been implemented to overcome those barriers. We expect to release a Year One report in fall of 2001 that describes the community strategies we have learned about. We hope to receive funding to develop case studies about a select number of specific community strategies in Year Two.
Purpose of interview	to learn about specific partnerships strategies being implemented in your community to improve low income families' access to good quality child care for their infants and toddlers.
Confidentiality	If there is anything we discuss today that you would like me to keep confidential and make sure could not be attributed to you or your organization or community, please let me know. In general, our report will contain general information about strategies and summarize the challenges and successes we learn about across the communities we are studying. Comments made during the interviews will not be attributed to specific individuals.
Strategies	
We are particularly interested in learning about your Early Head Start-child care partnership.	Can you give me an overview of the partnership? Why
	Why did you decide to form the partnership?
How did you recruit partners?	Flyers, ads, orientations?
	How do you "sell" the partnership to providers? What are the benefits to them?
	Are child care providers initially eager to participate or are they reluctant?
	Do you conduct assessment of providers' quality?
	Has this new funding improved the quality of infant-toddler child care that is available?
How many child care partners do you have?	Are they mostly center, family child care homes, or a combination?
	How long have they been in partnership with you?
	How many children does the partnership serve? How many children per partner?
Describe you contract with child care partners.	How did you decide on the terms?
	What does the contract require each member of the partnership to do?
	What are the payment arrangements?
	What training/technical assistance did you received in developing these contracts?
	Are there any terms you would change if you were developing the contract now? If so, why?

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TABLE A.4 (*continued*)

Key Topics	Detailed Questions and Discussion Points
What are the benefits of the partnerships for families? What does you partnership provide to support child care providers?	What additional support services do you provide to families through the partnership?
	Do non-EHS children cared for by your child care partners receive any EHS services or other benefits through the partnerships?
	Technical assistance? Visits? Developmental assessments? Quality assessment? Supplies? Recommend a specific curriculum?
	Who provides this support?
	What are important quality that you think provider liaisons should have in order to promote good relationships with providers?
How do you work with providers to reach compliance with the Head Start Performance Standards?	What are the most difficult aspects of the standards for partners to implement?
	Which aspects are implemented quickly?
	Which ones take longer to implement, and why?
	How many staff have attained a CDA credential within one year?
Are there other community partners that are working with you in implementing the partnership?	Contact information, roles
	Do you work with CCR&Rs through the partnerships? To identify providers? To provider technical assistance or training to providers?
	Do you receive support or technical assistance from the state or the ACF regional office?
What has been challenging about implementing this strategy?	Have there been challenges to community collaboration? Forming new partnerships? Developing contacts with providers?
	Has there been turnover of child care partners? What strategies have you used to reduce turnover?
	What are the challenges and benefits of working with existing child care providers versus providing child care directly?
	Has combining funding streams to pay for child care been challenging?
	Have differences in standards and requirements for various funding streams caused challenges?
	What have you done to overcome these challenges? Which approaches to overcoming the challenges has been most effective?
What has been accomplished so far?	To what extent are you meeting your goals? What do you think has made this partnership effective?
Other Contacts and Information	
Can we contact your child care partners?	Contact information
Can we contact other community partners involved in your partnership?	Contact information
Can you send us information about your partnerships?	Partnership contracts, application forms, assessment tools, goal sheets, other documents

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